OPINIONS OF OKLAHOMA REGISTERED NURSES REGARDING HEALTH SERVICES FOR MINORS WITHOUT PARENTAL CONSENT OR KNOWLEDGE

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CHAPTER I

INTRODUCTION

Two societal concerns that touch the lives or stimulate the interest of nearly every American citizen were unearthed during the 1970's. Their acknowledged existence has created sincere and intense questioning by religious, political, and educational organizations. One of the newfound interests was the current role, function, or even outlook for survival of the American family. The other concern was the impact, intended or unintended, that governmental laws or policies have had on the family. Individually these concerns attracted the attention of citizens and politicians interested in the American family. Together they commanded a concerted action for information as well as understanding. Numerous attempts have thus been made by government and individuals to assess and evaluate the state of the family and the impact of governmental policies on that unit.

Evidence of an upswing of interest in the family has been indicated through literature and popular media, including cinema. Government and privately funded programs addressing the family have also increased. The occurrence of the White House Conference on Families, the International Year of the Child, the Carnegie Council on Children, and Quality of Life Programs sponsored by the March of Dimes were but a few examples of public concern for the family.

A desire for the government to be accountable in its use of public funds, futuristic thinking, and a general response of the government for the good of the constituents it serves has been demonstrated by the initiation of environmental impact statements. Some individuals and agencies have sought similar accountability through impact statements relating to the family. The Minnesota Family Study Center, George Washington University Family Impact Seminar, and the state of Wisconsin served as leaders in family impact analysis. A host of policies affecting the family such as those on marriage tax laws, Aid to Families with Dependent Children, foster care, and care for the elderly have been targeted for study. The implementation of laws and policies relating to health services for minors was the focus of this particular research endeavor. Of special interest was the availability of health services for sexually active and/or pregnant minors.

In Oklahoma, the general framework under which health services for minors had been available was Oklahoma state law 63 O.S., Sections 2601-2602. (A copy of the text of this law is included in Appendix E.) Enacted in 1976, it allowed for a minor to consent to health services (except abortion and sterilization) if the minor was married, emancipated or had a dependent child, was separated from parents or guardian and not supported by them, was pregnant, was consenting for his or her child, was the spouse of a minor when the minor was unable to give consent, or was in need of emergency services for conditions which would endanger his or her life by waiting for consent from a parent or guardian. The prescribing of contraceptives to sexually active teenagers who were in danger of becoming pregnant was specifically identified as not constituting an emergency situation.

The law further stated that within this context the health professional should attempt to inform the spouse, parent, or legal guardian of emergency treatment but was not required to tell them of any other treatment needed or provided. When the minor was found not to be pregnant nor suffering from a communicable disease, the health professional was not to reveal any information whatsoever to the spouse, parent, or legal guardian without consent of the minor. If minors represented themselves to be adults the physician was able to service them. According to the law, minors who consented for services assumed the financial responsibility unless they were proven unable to pay and received the services at a public institution.

Statement of the Problem

Legally, for minors in Oklahoma to obtain medical services without parental consent or knowledge for conditions other than treatment for venereal disease, they must fall into one of the special categories of the Oklahoma state law 63 O.S., Sections 2601-2602. Limiting services to minors who are married, emancipated, separated from parents or guardian, pregnant, already a parent, or have a life-threatening emergency in effect limits services since these are the categories which most parents attempt to prevent their children from entering. Since these categories are considered by society as negative or undesirable, some children are reluctant to share information about these conditions with their parents. Therefore, the law is considered to be a problem by numerous agencies and individuals involved in serving minors because those desiring preventive services are discouraged from seeking them.

A 1980 telephone survey of Oklahoma county health departments revealed that a limited number of programs were then available for Oklahoma teenagers who were pregnant or parents (Jodar, 1980); however, most of the money and energy that had been spent on teenage pregnancy had been funneled into treatment rather than prevention. This expenditure was consistent with the nature of the law that provides services after sexual involvement rather than focusing on measures which prevent adolescent pregnancy.

One focus of this study was to determine what registered nurses believed about the relationship of present Oklahoma policies regarding health services for minors and (1) the incidence of early contact with health professionals by pregnant minors, (2) repeat pregnancies by minors, (3) unlawful abortions by minors, (4) lawful abortions by minors, (5) first pregnancies by minors, and (6) health risks incurred by minors in the state. The research also studied nurses' opinions about what health services were being provided for minors without parental consent, and what attitudes the nurses had toward the availability of these services. Also, it measured the extent to which nurses believed that minors knew of health services available to them without parental consent. Finally, it determined if there were differences in what nurses believed about the availability of services associated with the region of the state in which the services were sought.

Need for the Study

The legal rights of minors have not traditionally been the same as the legal rights of adults. The position of minors under the law has not always been clear nor has consensus on how the laws should serve

children been established. Laws related to health services are a case in point. There have been marked differences in the right of self-consent to receive services. These differences of rights have had special impacts for minors because even though minors needed the same health services related to reproduction that were used by the adult population they were discouraged from seeking these services because of the legal requirement of parental consent. Therefore, those minors who were unwilling to disclose their need for services to their parents were not eligible for health services unless qualified by one or more of the exemptions cited earlier.

Health services for minors has been an especially controversial area because of the considerations of parental rights and rights of minors when there was also critical timing for some health concerns. Pustular acne and obesity could be easily observed, however, a pregnancy could be hidden for several months, the critical first months in which medical care was important. Contraception needs may have been kept secret until an undesired pregnancy occurred and abortions that some families would have chosen may have been unavailable because of a delay in pregnancy confirmation or delay in informing parents. There has been concern that Oklahoma law discouraged minors from seeking health services when they were needed most.

The extent to which Oklahoma law regarding health services for minors has actually been enforced is not known. Sometimes because of personal or local viewpoints laws and policies have not been interpreted and implemented uniformly throughout the jurisdiction. Before it could be decided if a law had impacted a state, it was necessary to determine the extent to which the law was being observed.

A study was also needed so that family life educators, health professionals, human service personnel, and lawmakers could make recommendations and decisions concerning the provision of health services for minors. The fact that the subject of this research was an item of great public concern and dialogue and that numerous politicians and special interest groups were directly addressing its importance during the initiation of the study is another indicator of the need for additional information.

Limitations of the Study

This study was limited to a survey of registered nurses in the state of Oklahoma and was concerned with the laws of that state. Registered nurses were selected for participation because of their interest in teenage health problems and their contact with teens at the point of service delivery. Research data emphasized the important role of health professionals, who already have the confidence of parents and young people within their practices, in education and counseling of pre- and early adolescents (Adolescent Sexual Behavior, 1981).

Topics that relate to sexual matters usually have been considered difficult to study, especially when they pertained to minors. Both parental and adolescent permission were often believed necessary when seeking information that reflected on adolescent sexual behavior (Chilman, 1979a). This study attempted to obtain, without actually involving the minor, information on what minors knew about health services available to them without parental consent. Registered nurses who possibly provided the health care were asked their opinions of what minors knew about service availability. The investigator's belief was

that the person other than the minor most likely to have information about what the minor knew concerning health service availability was a health professional who was at the point of service delivery.

The mood of the country was in a state of change during the time of this study. Trends of liberalism that had influenced laws, policies, and attitudes both nationally and locally were confronting a revival of conservatism. Any effects these socio-political changes may have had on the responses obtained in the study are unknown.

Objectives

The objectives of this study were:

1. Obtain the opinions of registered nurses in Oklahoma regarding the provision of health services for minors without parental consent.

2. Determine if any relationships exist between nurses' opinions of the advisability and availability of health services for minors without parental consent.

3. Determine if any relationships exist between nurses' opinions of the advisability and their beliefs regarding minors' knowledge of availability of health service for minors without parental consent.

4. Determine if any relationships exist between nurses' opinions of the availability and their beliefs regarding minors' knowledge of availability of health services for minors without parental consent.

5. Obtain the perceptions of registered nurses regarding the impacts of Oklahoma law relating to health services for minors without parental consent.

6. Determine whether nurses' opinions of the advisability of health services for minors without parental consent varies with the

classification of the services as related or unrelated to sexual behavior.

7. Determine whether nurses' opinions of the availability of health services for minors without parental consent varies with the classification of the services as related or unrelated to sexual behavior.

8. Determine if any relationships exist among the major variables of study (advisability, availability, and minors' knowledge) and nurses' demographic variables.

9. Determine if place of employment is associated with the nurses' direct delivery of health services for minors.

Hypotheses

The null hypotheses tested in this study were:

H_1: There are no differences among nurses' opinions of the advisability of health services for minors without parental consent associated with nurses' opinions of the availability of health services for minors without parental consent.

H_2: There are no differences among nurses' opinions of the advisability of health services for minors without parental consent associated with nurses' opinions regarding minors' knowledge of health services for minors available without parental consent.

H_3: There are no differences among nurses' opinions of the availability of health services for minors without parental consent associated with nurses' opinions regarding minors' knowledge of health services for minors available without parental consent.

H_4: There are no differences among nurses' opinions of the

advisability of health services for minors without parental consent associated with nurses' demographic variables.

H_5: There are no differences among nurses' opinions of the availability of health services for minors without parental consent associated with nurses' demographic variables.

H_6: There are no differences among nurses' opinions of minors' knowledge of the availability of health services for minors without parental consent associated with nurses' demographic variables.

H_7: There are no differences in nurses' direct provision of health services for minors without parental consent associated with current field of employment.

Actually, each of the null hypotheses presented above represented nine or more sub-hypotheses. For example, null hypothesis number one required testing advisability by availability for 10 health services (10 tests). Null hypothesis number four required testing advisability of ten health services by each of 13 demographic variables (130 tests). To assist the reader in conceptualizing the research plan, Table I presents a summary of the variables included and the number of tests required by each of the null hypotheses.

TABLE I

SUMMARY OF VARIABLES INCLUDED AND NUMBER OF TESTS REQUIRED BY THE NULL HYPOTHESES

Variables	Null Hypotheses						
	1	2	3	4	5	6	7
Advisability	•	•		•			
Availability	•		•		•		
Minors' Knowledge		•	•			•	
Demographics				•	•	•	•
Direct Provision of Services							•
Total Tests Required	10	10	10	130	130	130	9

Assumptions

The assumptions listed below provided a basis for the study:

1. Access to high quality health care when needed is desirable for minors.

2. Health professionals have knowledge of the health services sought by minors.

3. The responses of the health professionals are representative of the profession whether the responses are based on actual experiences in the profession or on the beliefs and attitudes of the professional.

4. Registered nurses are familiar with the terminology used in the questionnaire.

5. Health professionals will respond to the best of their abilities.

6. Health professionals know the law under which they work.

7. Health professionals will respond from their own perspectives.

Definition of Terms

The following definitions were important to the development and understanding of this study:

Abortion Services - the forced expulsion of a fetus so early in the pregnancy that it was not viable outside the mother's body plus related counseling and health care both before and after the abortion.

Adolescent - a youth under the age of 20 who was capable of childbearing (Baldwin, 1981).

Advisability - nurses' opinions regarding health services that should be available to minors in Oklahoma without parental consent or

knowledge.

Availability - nurses' opinions regarding health services that are available to minors in Oklahoma without parental consent or knowledge.

Common to the Age - health concerns resulting from normal bodily processes or generally affecting adolescents regardless of behavior.

Contraceptive Services - family planning counseling and related health care as well as dispensing of medical and/or over-the-counter contraceptives.

Family Impact Analysis - a research framework for assessing the impact of legal and social policy on the family (Druckman and Rhodes, 1977).

Health Professional - any licensed physician, psychologist, dentist, osteopathic physician, podiatrist, chiropractor, registered or licensed practical nurse, or physician's assistant (Sixty-three O.S., 1976).

Health Services - services delivered by any health professional including examination, preventive and curative treatment, surgical, hospitalization, and psychological services (Sixty-three O.S., 1976).

Family Policy - a consensus on a core of family goals toward which the nation shaped programs and policy (Schorr, 1962).

Lawful Abortion - induced pregnancy termination performed by a licensed physician in a hospital or licensed abortion clinic that conforms with Oklahoma law regarding the length of the pregnancy and parental consent for minors.

Mature Minor Doctrine - a term in the medical care area endorsed by several states under which a minor who was sufficiently mature to understand the nature and consequences of medical treatment for his or

her benefit may self-consent for it (Paul, Pilpel, and Wechsler, 1974).

Treatment for Menstrual Problems - medical services for disorders of menstruation such as irregularity, pain (dysmenorrhea), excessive flow (menorrhagia), absence of menstruation (amenorrhea), intermenstrual pain and premenstrual difficulties (Miller, 1967).

Minor - defined by Oklahoma law as any person under 18 years of age except those who were on active duty with or had served in any branch of the United States Armed Services (Sixty-three O.S., 1976).

Minors' Knowledge of Availability - nurses' opinions regarding minors' awareness of health services that are available to minors in Oklahoma without parental consent or knowledge.

Treatment for Obesity - physical and/or emotional treatment for an overweight person by a health professional which may include prescription or diet, appetite suppressants, vitamin supplements, exercise, and/or counseling.

Parental Consent - consent provided by a spouse, parent, or legal guardian when the right of self-consent does not apply.

Pelvic Examination - visual and manual inspection by a health professional of the vagina and cervix and the size, position, and consistency of the uterus and adnexa (Harvey, Cluff, Johns, Owens, Rabinowitz, and Ross, 1968).

Pregnancy Testing - examination by a health professional that may include observation of uterus size, vagina hue, cervix softness, breast size and pigmentation, and/or laboratory testing of the woman's urine (Miller, 1967).

Treatment for Pustular Acne - medical services for a skin condition often characteristic of youth that includes whiteheads or blackheads

resulting from clogged pores that become infected and produce risen and pus-filled pimples (Miller, 1967).

Registered Nurse - a nurse residing in Oklahoma who was licensed by January 1, 1981, by the Oklahoma Board of Nurse Registration and Nursing Education for registered nurses.

Sterilization Services - counseling and health care related to sterilization as well as the voluntary process of surgical inhibition of the reproductive organs through vasectomy or tubal ligation.

Unlawful Abortion - generally construed to mean induced pregnancy termination that is performed by a person other than a licensed physician (including self-inducement), is performed outside a hospital if the fetus is more than three months old, is performed after 24 weeks gestation, except to prevent death or impairment to health of a pregnant woman. For other specifics of the law see 63 O.S., Sections 1-731 and 1-732 (Sixty-three O.S., 1980).

Treatment for Venereal Disease - medical services for healing and prevention of communicable diseases spread by sexual intercourse of which syphilis, gonorrhea, and chancroid are the most common (Miller, 1967).

CHAPTER II

REVIEW OF LITERATURE

Historical Perspective of Health Services for Minors

Not too far back in history health services for minors were nothing more than routine family business. Medical care, like discipline, nutrition, love, or cleanliness was part of the domain controlled by the parents or guardians. The government remained aloof to most domestic situations, including those that affected the life or health of children.

Slowly that detachment has experienced limited change and lawmakers have passed legislation aimed to protect the rights of minors to health (Coughlin, 1973). An example of such laws included one requiring doctors to administer prophylactic medicine to both eyes of every baby within two days of birth or be guilty of misdemeanor. This law was based on the infant's right to be protected from eye problems resulting from venereal disease and it removed from the parents the right to make this decision for the child.

Another example of law (Coughlin, 1973) that took away from parents the right to decision was one requiring children to meet community health standards by making it mandatory for parents to supply the schools with a statement of vaccination for the child. The purpose

of the law was to identify and protect youth whose parents have no acceptable explanation for school authorities of why their child was not vaccinated.

Frederickson and Mulligan (1972) considered it a special problem in health care when parents' beliefs or wishes conflicted with the need for preventive or therapeutic health services for their children. Refusal of immunizations, blood transfusions, or surgical and medical care because of religious conviction, ignorance, or apathy has led to intervention by juvenile courts in securing services for children on the grounds that interests of a child may ultimately take precedence over the rights of parents to family autonomy and non-intervention by the state.

Although the right to life for children may have seemed self-evident to most people, Forer (1973) indicated that parents today who failed to provide or refused medical treatment for their children may have been no different from parents in history who, to the shock of the American conscience, sacrificed, maimed, exposed, or exploited their children. Disability from lack of available treatment was considered no different from disability due to brutal treatment.

The courts have had the right to order medical care for neglected or abused children (Pilpel, 1975) or for the child who was delinquent (Forer, 1973). In fact, the criminal child may have received needed treatment ordered by the juvenile court whereas a child who was acquitted or discharged did not get medical care unless it was voluntarily provided by the parents.

Forer (1973) further stated that there were few statutory laws governing health care for children. Medical treatment has not been

recognized as a constitutional right. Although some free clinics have been established and some entitlements were prescribed under aid to dependent children programs, there have been few programs for which a child could claim benefits for himself.

Older children have been as much at the mercy of adults as infants have been in respect to obtaining medical care. Few of them have been able to consult a physician on their own. Parental permission has been required for hospital treatment even when a teenager had personal money and voluntarily sought help (Forer, 1973).

As was suggested by Frederickson and Mulligan (1972), children's health care has been dependent upon parents who may or may not have had their children's best interest in consideration. The need for advocacy for children has been made obvious and it has become especially clear for the adolescent who was in the transition period between parental dependency and self-responsibility.

Pilpel (1975) stated that the old common rule law requiring the consent of a parent or guardian before a doctor could treat a minor for anything has contributed to the difficulty young people have had getting medical services. She said that although there were always exceptions to the old common rule law, doctors, hospitals, and health agencies have been reluctant to treat youth without specific legal protection. They felt that to treat minors without consent might expose themselves to suits for technical assault or malpractice making them liable for damages and possibly to crimical charges as well.

The ability to pay for medical services was one factor Keniston (1977) reported as affecting beliefs concerning parental control over their children's right to health care. Although he admitted that

parent-child rights were a thorny issue, he indicated that lifelong health habits, including attitudes about the use of health services and one's personal responsibility for health were established during childhood and he stressed that a child's potential independence and informed consent to care would have valuable effects over a lifetime.

The interest and changes in provision of health care for minors have not been fast. They have received recent impetus, however, from such social forces as civil rights, women's liberation, the sexual revolution, and consumer control. These thrusts have emphasized not only rights of those receiving services to participate in the decision making, but in the need for services to be age-appropriate (Howard, 1975).

An Overview of Family Policy

It has become increasingly recognized that the needs and rights of children as seen by the children themselves have not necessarily been the same as those supported by adults acting on the children's behalf. The needs and rights of adolescents who were still considered minors have been especially challenged in the area of health care. The legal rights of minors to receive health care without parental consent or notification have been an issue that has been seen as having had definite impact upon the family. Teenage pregnancy has also affected the family. Efforts by lawmakers to regulate minors' legal rights or the outcome of sexual conduct have been making, in a real sense, a statement regarding family policy.

The need or lack of need for a national family policy in the United States was a popular discussion issue in the 1970's. A

heightened interest in the family and in governmental accountability produced a fertile arena for debate concerning family policy.

Some family researchers contended that parents and public advocates for children needed to take more of a lead in political action. Keniston (1978), working with the Carnegie Council on Children, outlined a national program; a broad, integrated, explicit family policy, that they believed should be supported. The policy included support for jobs and decent living standards, flexible working conditions, an integrated network of family services, proper health care for children, and legal protection for children outside and inside their families.

Bane (1976) asserted that regulation has historically been an ineffective way of dealing with family problems. She pointed to the fact that Americans have gotten along without a family policy for two centuries and that the arguments delivered supporting one now are not valid. Bane noted, however, that present societal commitments may require regulation of some family functions.

On October 1, 1980, United States presidential candidate Ronald Reagan announced formation of a family policy advisory board. The two-fold purpose of the board was to promote national rededication to traditional American family values and to critique the results of the Carter White House Conference of Families report. In speaking about the advisory board, Reagan said, "Government has intruded into the traditional relationship between parents and children . . ." (The Reagan Administration, 1980).

Most authorities on family policy agreed that no modern industrial society could avoid policies that affected the family (Kamerman and Kahn, 1967 and 1976; Druckman and Rhodes, 1977). This created somewhat

of a problem in the United States because of the American tradition of minimal government. Individualism and privacy have been an integral part of democratic belief (Schorr, 1962).

There was indeed a dilemma concerning family policy. Worth of the individual had been valued for so long that consideration for support of the family as a unit was requiring a new way of thinking. Some public policy programs, in helping individuals, were recognized as maintaining an anti-family bias. Examples were survivor's insurance that ceased when the widow remarried and aid to families with dependent children that was primarily for homes in which the father was absent. Axiin and Levin (1972) advocated the need for public policy which would optimize choices for families and at the same time explore the ways in which family goals and individual goals could be mutually enhancing.

According to Nye and McDonald (1979) family policy research has had two models emerge. One of the research models was family evaluation research. This was a systematic analysis which assessed the degree to which stated goals for individuals as members of families and the family unit were achieved.

Family impact analysis was the second model to be accepted by researchers. As with family evaluation research, family impact analysis focused on stated goals or intended consequences of public policy for families. Social programs were recognized, however, as affecting families in various ways other than the explicit intentions of the policy. Some of the ways families were affected were counter-productive even though the intended goals were achieved.

Family impact analysis was conceived as a framework for objectively assessing how the family was affected by legal and social policy. The

intended goal of family impact analysis was to generate family impact statements to accompany public policy reports. The family at three levels of concern was targeted: the family as a social institution, the family as an interacting group, and the individual family members (Druckman and Rhodes, 1977, and Nye and McDonald, 1979).

Early family impact analysis work took place at the Minnesota Family Study Center, the George Washington University Family Impact Seminar, and the Center for the Study of Family and the State at Duke University. These workshops produced different but compatible models for family impact analysis.

As the models evolved it became apparent that family impact analysis was not simple. The definition of the family itself was under scrutiny. The fact that families were in different developmental states and had different needs was an issue. The competencies and biases of the researcher were noted as significant. Discerning manifest or latent purposes of the policy and direct or indirect consequences was a necessary but uneasy task.

Family impact analysis explained existing consequences of presently implemented policies while attempting to predict the range of future consequences. The analysis was a tool for measuring whatever the government was doing that touched families but according to Nye and McDonald (1979) perhaps its greatest potential was in social forecasting of proposed policy and program impacts.

One of the present social issues that has demanded legislative, judicial, and medical decisions has been medical self-consent for minors. The impact of allowing minors to have rights to medical care without parental consent or notification in relation to family discord

and disunity was reviewed by Crutchfield (1981). By citing numerous court cases pertaining to the rights of minors to receive medical treatment without parental consent, he concluded that the courts have impacted heavily upon the family structure by discouraging parent-child communication and harmony. He also suggested that the courts' rulings on contraception and abortion have produced sexual permissiveness in the nation. According to Crutchfield, these were not consistent with the traditional family policy generally stated as the best interest of the family.

Zimmerman (1981) and Rodman (1981) disagreed with Crutchfield (1981) that the results of a liberal interpretation of children's rights concerning health services necessarily disrupted family unity. Zimmerman stated that most families are untouched by the issue of parents' and children's rights in relation to medical treatment and thus the issue did not preoccupy family time. She also suggested that delineation of the quality of rights for both parents and children could earn each person respect and in that way actually impact the family through improving family relationships rather than destroying them.

Rodman (1981) proposed that it may even be more explosive for the family when a child is forced to confront the family with a highly charged issue such as contraception or abortion than it would be if parental consent or notification were not required. Rodman acknowledged that the family strengthen-weaken argument could be supported from either direction, however, he included examples of situations where court requirement of parental consent or notification or even further court action had unfortunate results. He questioned the role of the

court in interfering in individual decisions when the court's purpose was supposedly aimed at maintaining a family harmony that was obviously lacking or the minor would have voluntarily discussed the situation with the parents.

Oklahoma Law Relating to Health Services for Minors

One of the facets of health services for minors without parental consent or knowledge that has received nationwide attention is health care related to adolescent pregnancy. The problems of adolescent pregnancy in Oklahoma have been defined. An Executive Summary prepared for the Oklahoma Human Resources Mini-Cabinet by the Sub-Committee on Teenage Pregnancy (Jodar, 1980) reported that during 1979 over 17,500 Oklahoma teenagers became pregnant. This represented 16 percent of all teenage girls in the state and has ranked Oklahoma ninth in the nation in incidence of adolescent pregnancy (Maze, 1981).

Knowledge of this and the implications it has had on teens and their infants has resulted in requests by numerous influential agencies within the state for legislative action aimed at reducing adolescent pregnancy. The Task Force on Youth and Families to the Governor's Committee on Children, Youth, and Families, the Oklahoma Health and Welfare Association, the Oklahoma State Medical Association, the Central Oklahoma Pediatric Society, and the Oklahoma Health Systems Agency, Incorporated have each adopted resolutions or policy statements publicly acknowledging the need for action that would minimize teenage fertility.

Current laws in Oklahoma have not addressed pregnancy prevention in adolescents as a specific issue. They have provided reference to adolescent pregnancy and fertility control through laws relating to health services for minors. Oklahoma state law 63 O.S., Sections 2601-2602, titled Health for Minors (Sixty-three O.S., 1976), covered definitions, right of self-consent, payment for services, safeguards to protect minors, non-mandatory provision of health care, and severability. (See Appendix E for a complete copy of the law.)

In reference to pregnancy related health services for minors, the law allowed the minor to give self-consent if the minor (1) was married, emancipated, or had a dependent child; (2) was separated from or not supported by her parents or legal guardian; (3) was or had been pregnant; (4) was consenting for her child; (5) was consenting for a spouse who was unable to consent due to physical or mental incapability; or (6) needed emergency services for which delay would endanger her life or health. Self-consent for medical services for a sexually active minors was not listed.

Especially noted in the law was a statement that the prescribing of medicine or device for the prevention of pregnancy was not considered an emergency service. It also was stated that if a minor were found not to be pregnant the health professional should not reveal any information to her parents, guardians, or spouse without the minor's consent. As was mentioned earlier, minors who were pregnant had the legal right to obtain services without parental consent or knowledge.

A minor was defined by the law as any person under 18 years of age except those who were on active duty with or had served in any branch of the United States Armed Services. Military personnel were

considered adult.

The definition of health services specifically excluded abortion and sterilization from its list of professional treatments. The definition also stated that should the health service include counseling for abortion, all alternatives should be presented to the minor.

Since the 1976 adoption of the previously mentioned law, numerous Supreme Court decisions regarding adolescent fertility and pregnancy have been made which have created new interest in interpretation of Oklahoma state law 63 O.S., Sections 2601-2602. The U. S. Supreme Court ruled in the case of Jones v. T. H. that the Utah Division of Family Services could not require parental consent for family planning services since that was in conflict with the Social Security Act (Social Security Act, 1976). Title XX of the act stated that

> a state plan for aid and services to needy families with children must . . . assure that in all appropriate cases (including minors who can be considered sexually active) family planning services are offered to them . . . (Social Security Act, p. 637).

The Medicaid program, Title XIX, required that state Medicaid programs must cover family planning services and supplies furnished to individuals of child bearing age, including minors who were considered sexually active, who desired such services and supplies.

Oklahoma Attorney General Opinion No. 76-241 (Minors-Family, 1976) issued December 6, 1976, stated that Oklahoma statutes did not on their face fall in the same category as Utah's law. It further stated that a legislative enactment was presumed valid and was nullified only upon showing that it was clearly not valid. Further questions concerning the application of the provisions of this law and their conflicts with

the Federal Social Security Act were to be directed to the Social Security Administration.

The June 9, 1977, U. S. Supreme Court decision in the case of Carey v. Population Services International (Carey v. Population Services International, 1977), prompted another request for an Oklahoma Attorney General opinion. Carey v. Population Services International challenged the constitutionality of a New York statute that made it illegal for a person to sell or distribute contraceptives to anyone under the age of 16, for anyone other than a licensed pharmacist to distribute contraceptives to persons over 15, and for anyone to advertise or display contraceptives. The U. S. Supreme Court held that all of the provisions of this New York statute were unconstitutional. A 1977 request for an Attorney General opinion of distribution of contraceptives to minors in Oklahoma in view of the Carey v. Population Services International decision has not been answered by Oklahoma's Attorney General at the time of this writing.

A July 2, 1979, U. S. Supreme Court ruling (Bellotti v. Baird, 1978) said a Massachusetts statute stating that parental consent is necessary before an unmarried woman under 18 years of age can obtain an abortion was unconstitutional. The Bellotti v. Baird decision made it clear that state laws requiring parental consent for minors to obtain abortions were not valid. The Bellotti v. Baird decision also invalidated state statutes requiring parental notification in all cases before a minor daughter received an abortion.

Since this Supreme Court ruling Oklahoma's statutes concerning a minor's right to abortion without parental consent or notification have received considerable publicity. A 1981 decision in Oklahoma City,

Oklahoma, ordered an abortion for a 12 year old girl whose mother objected to abortion for religious reasons (Manning, 1982). The young girl, a victim of gang rape, had contracted a venereal disease. The Supreme Court of Oklahoma heard and upheld the abortion order and although the child withdrew her request, the judge trying the case indicated that should such a case be heard again it is likely that the Supreme Court will again uphold the right of the child to make the decision.

A U. S. Court of Appeals decision (Doe v. Irwin, 1980) on February 26, 1980, that had possible implications for Oklahoma law was the Doe v. Irwin case in Michigan. This case concerned a family planning clinic's distributing contraceptives to minors without notice to their parents. In deciding this case, the judges acknowledged three distinct rights; the rights of personal privacy (including some constitutionally protected rights of minors), the rights of parents to the care, custody, and nurture of their children, and the rights of the state to be interested in the health and welfare of its inhabitants. The judges recognized the desire of parents to know of their children's activities but did not feel that parental rights were being infringed upon because of the distribution of contraceptive devices and medication to unemancipated minors without notice to parents.

There was during the time of this study a settlement made in Tulsa, Oklahoma, where Planned Parenthood was sued for providing contraceptives to a minor after which medical problems allegedly resulted. This case, filed on October 29, 1980, by the parents for their daughter sought $3,856,000 to cover past medical expenses and future pain, suffering, medical expenses, loss of services, and punitive damages.

This case (Smart v. Planned Parenthood of North-Eastern Oklahoma) was reportedly settled out-of-court. Results of the nature of the settlement were not available to the public. Therefore, it is not known in whose favor the case was decided.

Another event of relevancy to this project was a 1982 federally proposed rule (Requirements Applicable, 1982) that would require notification within 10 working days to parents of unemancipated minors seeking family planning services when prescription durgs or devices are provided. If state law required notification before contraception was provided, then the state would have to comply with that stricter interpretation. Even in states where age 12 was recognized as emancipated for purposes of medical treatment, for the federally assisted family planning programs youth of 17 and under were to be considered unemancipated. At the time of this writing the proposed rule was still under consideration.

Adolescent Pregnancy Overview

Teenage pregnancy has been occurring for centuries but it has been deemed by today's society as a modern-day problem. Delayed age of marriage, prolonged education or occupational training, recognition of medical risks for young mothers and their offspring, emphasis on overpopulation, costs to taxpayers through welfare payments, and a growing American value in the worth and rights of children have all contributed to the labeling of adolescent pregnancy as an unwanted dilemma.

Although the age at puberty and its resultant sexual drive has lowered in the past few generations, the actual age at which sexual expression is currently socially accepted has been raised. Early

menarche, resulting from improved nutrition, living conditions, medical services, and overall health, has made it physically possible for young girls to become pregnant at earlier ages. Prolonged adolescence resulting from older age at marriage has helped create a setting for out-of-wedlock pregnancies.

According to Chrisman (1920) the age of marriage was considerably younger in the historically ancient child than it has been in recent years. Girls were often married as young as 12 years old in Persia, Rome, and England. They could not be married under 12 years and 1 day in Judea. A young girl in Japan was often married by age 13 and in Greece she wed between 15 and 20 years of age. In Mexico girls were also married before 20.

Writings about India stated that

> Although no law has ever said so, the popular belief is that a woman can have no salvation unless she is formally married. Parents often become anxious if a daughter over 8 or 9 is unsought in marriage. The feeling is so strong that parents would often marry girls of 8 or 9 to men who were 60 or 70. Boys among Brahmins married at about 16 years of age and girls were usually 5 or 7 or at the utmost 9 years of age. Among the Brahmins if a girl remained unmarried until 11 years old the family was suspended from the caste (Chrisman, p. 92).

Roman law also influenced youthful childbearing. It stated that a woman who was 20 or a man who was 24 years of age and who was childless became liable to a decree by Augustus against childlessness and celibacy.

The young girl in the American colonies was also married at 15, 16, or less. She was rarely given the opportunity to get much older because of the scarcity of women in the new country.

Theologians believed that Mary, the mother of Jesus, was probably no more than 14 when she bore Him. Girls in Israel during the time of

Jesus were married as soon as they were physically ready for marriage, which, according to the law, was at the age of twelve and a half (Daniel-Rops, 1962).

Vinovskis (1981) and Baldwin (1980) reported that recent history indicated the actual rate of adolescent childbearing had sharply decreased in the past 20 years. This was not true, however, for the young 10 through 14 year age-group whose fertility rate increased by one-third in the past 11 years. Vinovskis contended that since neither the rate nor number of pregnant adolescents supported such public concern as was being exhibited, the real reason for the problem was that an increasing proportion of teens were having their children out-of-wedlock. Out-of-wedlock births had more than doubled in the 20 years since 1960. The American society became upset because of the burden placed upon taxpayers when so many adolescents who had little or no means of support were choosing to keep their infants. State and federal welfare programs were greatly expanded to meet the costs of these single-parent children. Alan Guttmacher Institute (Teenage Pregnancy, 1981) figures showed that three to five times more teens than older women depended on the government to pay for delivery.

Children have been born out-of-wedlock since the beginning of weddings. Early records showed that the attitudes toward illegitimacy depended on cultural traditions and was to some extent reflected in provision of law (Young, 1954). In some primitive tribes, then as now, a young woman who had borne a child was considered a more eligible spouse that one who had not had one (Frederickson and Mulligan, 1972).

Over one million girls in the United States aged 15 through 19 were said to become pregnant each year (Eleven Million, 1976). An

additional 30,000 girls 14 and under were reported to become pregnant. These figures, released by the Alan Guttmacher Institute in 1976, made the headlines in newspapers, weekly magazines, and countless reports. They became the topic of television talk shows and the daily news. A subject that had traditionally been shunned and avoided was brought to national attention. In fact, lowering the incidence of teenage pregnancy became a national goal (Roundtable Report, 1981).

An alarming number of adolescents were producing babies without financially, emotionally, or physically being ready to care for them and the problems for these teens engaged in childbearing were numerous. Education was frequently interrupted, repeat pregnancies often occurred soon after the first pregnancy, and employment opportunities became limited due to childrearing responsibilities and lack of education. Each of these problems increased the possibility that the youth would be poor, would have a low income husband, and would separate from that husband and eventually divorce (Moore, 1978). Personal freedom became a limited commodity for the teenage parent and dating was often affected. New and awesome responsibilities for the adolescent made decision making assume a new height of importance (Nye, 1976).

Health hazards associated with early childbearing became a concern for the medical community (Kamerman and Kahn, 1976). Toxemias, urinary infections, anemia, prolonged labor, obesity, and Caesarean sections were all complications especially associated with teen pregnancy.

Lincoln (1978) emphasized that pregnancy was not good for teenagers. According to him, 50 percent of girls experienced pregnancy before leaving their teenage years. Two-thirds of the teenagers who became pregnant did not want to be pregnant and one-third of the

pregnancies were terminated by abortion.

Kasun (1978) disputed Lincoln's findings saying that two-thirds of the births to teenagers were to young married women who were starting their families. She also reported that the younger the mother the less likely she would have a baby with Down's Syndrome and that the incidence of breast cancer was lowest among women who had their first child under the age of 20. Kasun admitted that young mothers recently have had a larger proportion of their children outside of marriage.

The young mother is not the only one whose health and social welfare have been investigated. Infant mortality rates have been considerably higher for children born to teenage mothers than to those in what is considered to be the prime childbearing years. The children of teen mothers have had deficits in cognitive development, lower I.Q. scores, more difficulty adjusting to school, and more time spent in single parent homes. These children had poor social-emotional development and were more likely themselves to have children as adolescents (Baldwin and Cain, 1980).

Bruce (1978) and Pochin (1969) suggested that adolescent pregnancy also impacted on the young parent's parental family. There has been troublesome disparity between adolescent pregnancy and certain cultural values and expectations. The family's reputation was often questioned and a burden was placed on the family's resources. Adolescent pregnancy interfered with the orderly launching of the child into marriage and employment. Parents saw it as a rejection of themselves because it was a rejection of the role of the child. Adolescent pregnancy reminded the parents of their own mortality because as their children were on the way up, the parents were on the way down.

Sister Margaret Mary (1968) also addressed the concerns of the parental family.

> In addition to counseling the unmarried mother, the social worker also has the responsibility of attempting to counsel the unmarried girl's parents. The need for help to the family is self-evident. The unwed mother is always a part of her family. Even when she is not living with them she is subject to -- and reacts to -- the family's influence . . . . If the father of the child is in the picture, he, and hopefully his parents, should also be included in the decision making (p. 65).

Counseling for both the mother's parental family and the father's parental family was advocated by Bernstein (1971). As decision making took place for the unmarried parent, conflicts with the parental family needed to be resolved. Decision making seemed to be an important factor in the young pregnant girl's life. Often one of the first things she lost after pregnancy was her right to make decisions. A minor unmarried mother often had to have parental consent before she could receive medical or social care.

In the medical care arena, several states have endorsed the "mature minor doctrine". Some states passed specific legislation allowing consent for medical care in general or contraceptive services, pregnancy related care, or treatment for venereal disease in particular. Changes in teen legal rights also included many states lowering the age of majority from 21 years of age to 18. This followed the adoption of the 26th Amendment which permitted 18 year olds to vote.

The right of minors to buy medical contraceptives or seek abortions without parental consent or knowledge has been a smoldering concern. With the emergence of sexual matters from their veil of secrecy, it "became obvious that people were engaging in heterosexual activities with greater frequency and that they had begun doing so at an earlier

age than ever before in United States history" (Byrne, 1978, p. 28). Zabin, Kantner, and Zelnik (1979) reported that one-half of all initial premarital teenage pregnancies occurred in the first six months of sexual activity. More than one-fifth occurred in the first month, a time when contraceptives are least likely to be used.

Young (1954) indicated that unmarried mothers did not consider using contraceptive devices. Green and Potteiger (1977) reported that 94 percent of teens had intercourse before seeking contraceptive services. Seventy-five percent had been sexually active for one year before seeking contraception. A list by Chilman (1979b) included lack of access to free, confidential, personally reassuring family planning services that do not require parental consent as one of the situational variables affecting adolescents' use of contraceptives.

Byrne (1978) and Zabin, Kantner, and Zelnik (1979) agreed that the age of first intercourse is becoming younger. Lincoln (1978) reported that 10 percent of 13 year olds had premarital sexual experience. One factor in explaining high risks of pregnancy was early age at initiation of intercourse. Those who first had coitus at age 15 or younger were nearly twice as likely to get pregnant in the first six months of sexual activity than those who waited until 18 to 19 years of age. This occurred because those who first have intercourse at an early age were unlikely to use contraception (Zabin, Kantner, and Zelnik, 1979). Chilman (1979b) concluded from a summary of several studies that contraceptive use was likely to increase with age.

Edwards, Steinman, Arnold, and Hakanson (1980) said that a majority of teenage pregnancies were unplanned and could be traced to a lack of knowledge about the risks of pregnancy, how to prevent it, or

the availability of services designed for adolescents. Tietze (1978) suggested a 40 percent reduction in adolescent pregnancies if young people were to consistently use contraception. The rate would be reduced further if medical contraceptives were used. A 1976 study by the Urban and Rural Systems Association, reported by Chilman (1979a), listed nine reasons why teenagers claimed they did not use family planning services. Requirement of parental consent, lack of confidentiality, poor clinic location and high visibility of the service, cost of service, long waits for appointments, inconvenient hours when teens were at school or were required to be home, lack of knowledge that services existed, attitudes of clinic personnel, and female orientation of the clinic were all factors hindering adolescent use of facilities.

There has been considerable reluctance to provide youth with the conditions that would permit them to utilize what they know. For example, many times contraception was unavailable without parental consent (Byrne, 1978). Parental notification or consent would cause a substantial number of young people who were not protected to use no contraception at all or to use a less effective non-prescription contraception (Torres, 1978).

A study reported by Torres (1978) found that more than half of the teenagers in the survey said that their parents knew they were getting contraceptives. This fact challenged one of the principal premises underlying efforts to secure parental notification laws, namely, that minors will not inform parents about their sexual activity and contraceptive practices unless forced to do so. Torres concluded that parental notification laws would be redundant for a majority of teens and result in more pregnancy among those unable to talk to their

parents.

A 1971 study by Moore and Caldwell (1974) showed that availability of legal abortion had a statistically significant impact on the outcome of pregnancy. Females who resided in states in which abortions were legal and available reported more abortions than those in states where abortion was somewhat restricted. Lower black teenage out-of-wedlock fertility was related to subsidized family planning while abortion availability predicted lower white out-of-wedlock fertility. Braen (1971) was convinced that since abortions were not freely available to this age group, the effects of illegal abortions were the greatest causes of maternal death in school-age children. Governmental policy had definite effects on teenage pregnancy.

Of particular significance to a study on policies affecting pregnant adolescents was research conducted by Lewis (1980) in which pregnancy decision making of unmarried minors was compared to that of unmarried legal adults. An important finding of this research endeavor was that adult subjects were more likely than minor subjects to plan consultation with a professional than with a boyfriend, parent, or other person who had strong vested interests in whether or not the pregnancy continued. Minor subjects were more likely to consider the effects of their decisions on their parents and families than the adults were. Minor subjects also made more of their decisions based on considerations such as parental pressure. The minors perceived that their decisions were determined by external factors rather than being their own free choices.

The minors reported in this study did not differ from the adults studied concerning their knowledge of the legality and confidentiality

of abortion. Legal misinformation was not a cause for how they made pregnancy decisions. The minors and adults did not differ significantly in their knowledge of contraceptives but minors did mention that the type of contraceptive method used was often selected because of their fear that their mothers would find what they were using.

CHAPTER III

DESIGN OF THE STUDY

Population and Sample

Registered nurses holding certificates permitting practice in Oklahoma from July 1, 1980, to June 30, 1982, and living in Oklahoma in May and June of 1981 were the subject of this study. There were no limits regarding the field of employment, sex, age, or any factors other than being a registered nurse in Oklahoma who could practice in this state.

A sample of 446 nurses was drawn from over 9,000 names listed by the Oklahoma Board of Nurse Registration and Nursing Education. The sample was randomly determined by computer. The state regions were not intended to be equally represented but the randomness was to assure a representation equal to the number of nurses in the area's population. A distribution of the sample is provided in Appendix C.

Instrumentation

The data collection instrument developed by the researcher had four major parts. Part I was designed to obtain registered nurses' opinions of the advisability, availability, and minors' knowledge of availability of health services for minors without parental consent. Ten health services of common concern to minors were selected for study. The order of listing the services in the questionnaire was determined

by random selection process. A copy of the instrument is included in Appendix A.

The ten services were identified from suggestions in the literature and were chosen so that five services represented health needs that were related to sexual behavior and were considered value-laden or as dealing with morality. The other five services were considered common to the age and were not associated with sexual conduct. The health needs that dealt with sexual behavior were (1) contraception services, (2) treatment for venereal disease, (3) abortion services, (4) sterilization services, and (5) pregnancy testing. The health needs not associated with sexual conduct were (1) treatment for pustular acne, (2) treatment for menstrual problems, (3) treatment for obesity, (4) pelvic examinations, and (5) breast examinations. Although gender was not a variable identified for this study, several of the health services listed in the questionnaire were gender specific. Since adolescent pregnancy was a major interest in this study, the services related to contraception, venereal disease, abortion, sterilization, and pregnancy testing were included.

Given specific questions about the 10 services that could be provided for minors by health professionals, participants were asked to respond on a five point Likert-type scale. Choices on the scale were undecided, strongly disagree, disagree, agree, and strongly agree. To reduce the risk of respondents tending toward the middle column, the undecided column was moved to the first column of the questionnaire. This move was made to encourage commitment and to reduce the possibility of a meaningless average.

The responses indicated the nurses' beliefs about three different

aspects of the 10 services. Part I of the questionnaire determined (1) whether nurses believed each of the 10 services should be available in Oklahoma without parental consent; (2) whether nurses believed each of the 10 services were available in Oklahoma without parental consent; or (3) whether nurses believed minors knew if each of any of the 10 services were available in Oklahoma without parental consent.

Part II of the instrument concerned the nurses' perceived impacts of Oklahoma law regarding health services for minors without parental consent. In this section, Oklahoma state law 63 O.S., Sections 2601-2602 were discussed. Respondents were then requested to provide their opinions of the impacts of the current law on another five point Likert-type scale. Six possible impacts of the law were listed. These six impacts were areas that were frequently noted in the literature as being concerns for pregnant minors.

The six impacts included were (1) early contact with health professionals by pregnant minors, (2) repeat pregnancies by minors, (3) unlawful abortions by minors, (4) lawful abortions by minors, (5) first pregnancies by minors, and (6) health risks incurred by minors. The impacts were randomly listed on the questionnaire. The five point scale ranged from one, which indicated an increase, to five, which indicated a decrease in the impact the law was having. Three, the mid-point on the scale, represented no impact.

The nurses were requested to provide written comments in Part III. They were asked to respond to three questions dealing with possible changes in Oklahoma law concerning provision of health services for minors. The three questions addressed whether a change was advisable in Oklahoma law relating to health services for minors, what changes if

any were recommended, and for what reason the changes were suggested. (See Appendix D for unsolicited comments that were not analyzed but provided insight into respondents' beliefs.)

Part IV of the instrument requested background information. The number of years worked in health services, number of years worked in the present community, state planning district in which currently employed, present role in provision of health services for minors, and field of employment were the personal data sought. The 11 state planning regions used were those designated as economic development districts by the Oklahoma Health Systems Agency, July 1, 1976. A map was attached so that the respondents could identify the region(s) in which they worked. The fields of employment listed were obtained from the Oklahoma State Department of Health and included hospital, nursing home, school of nursing, private duty, public health, school nurse, industrial nurse, and office nurse. A space was provided for nurses to add any field of employment not included in the list.

The comments and background information requested were chosen because the investigator believed these items addressed the objectives of the study. Information not specifically needed to satisfy the study objectives was not included on the questionnaire.

The Health Services for Minors Questionnaire went through several revisions before completion. Early drafts were reviewed by the State Department of Public Health director of nursing services, members of the researcher's doctoral committee, and interested home economics faculty at Oklahoma State University. After the investigator and committee chairperson reviewed the comments and suggestions, a more complete form was prepared and administered to the Payne County Advisory Board on

Adolescent Problems. The investigator personally presented the questionnaire to the advisory board and made note of oral comments and suggestions as well as those written on the questionnaire. This panel was selected to review the questionnaire because of its interest in adolescent pregnancy and the qualifications of its members.

Further advice and review for validity was obtained from physicians, a statistician, and several home economists. The questionnaire was finalized by the investigator and committee chairperson after discussing and weighing all suggestions.

Data Collection

Data for the study were collected in the spring of 1981. The three page questionnaires with an attached regional planning districts map, cover letter, return envelope, and participation card were mailed on April 24. Responses were requested by May 8. On May 30, 1981, questionnaires with letters, return envelopes, and participation cards were again sent to all sample names that had not returned a participation card. A response from this mailing was requested by June 15. A copy of the cover letter sent with each mailing may be found in Appendix B.

All questionnaires were sent by first class mail. Pre-stamped self-addressed envelopes and participation cards were enclosed for participant use.

A nurse's specific identity or the county in which the nurse was employed was not of interest to the study. The separate participation card provided anonymity to the respondents while it allowed records to be kept for efficient follow-up procedures.

At the close of the data collection period 199 nurses had responded. Two other nurses were known to be ineligible because of death and eight more were identified as ineligible because they responded that they had moved out-of-state. Eight questionnaires were returned by the postal service because of address change. The response rate for nurses believed to be eligible was 46.5 percent. It is not known how many of the non-respondents were in fact not eligible.

A follow-up was made for 10 percent of the non-respondents. From the list of nurses who had not returned participation cards, 23 names were randomly chosen for a telephone interview. An abbreviated questionnaire was used for the non-respondent questioning. Of the 26 names, phone number were located for 13 nurses. Six of these nurses participated in the follow-up survey. Of the other seven, one had moved out-of-state, three said they had returned the questionnaire, two were not home for five calls, and one was not interested in cooperating. Information obtained from the follow-up was too limited to facilitate a comparison of the characteristics of respondents and non-respondents.

Data Preparation

Data obtained from the questionnaire were transferred to coding sheets and keypunched for data analysis. The Computer Center at Oklahoma State Univeristy and Statistical Analysis System computer programming (Helwig, 1978) were used for the random sampling and all analyses.

Data Analysis

Results of portions of the data collected were summarized and

reported as frequencies and percentages. The statistical procedure employed for other data was a two-way chi square analysis. A probability level < .05 was used as the basis for establishing significance. According to Linton and Gallo (1975) the qualifications for a two-way chi square included tests of association, two independent variables, more than two levels of either variable, and between subjects. The data resulting from this study met this description.

The data also qualified for chi square analysis considering the restrictions for chi square usage: the raw data were presented as frequencies; each subject was counted only once; logical classification categories were set up before the data were collected; and nonoccurrence of the event was recorded as well as occurrence. When expected frequencies were fewer than five in 20 percent of the cells of an contingency table, a warning was automatically noted by Statistical Analysis System (Helwig, 1978) that chi square may not be a valid test. In cases where warnings were observed, the researcher carefully analyzed the data cell by cell and judged the validity of the test by examining the relationship of the cell chi square values (contributed by cells having expecteds less than five) to the total chi square value.

CHAPTER IV

RESULTS AND DISCUSSION

This study was concerned with the opinions of health professionals regarding health services for minors in Oklahoma without parental consent. This chapter presents a description of the population surveyed and results from the analysis of the data. The findings of the study are presented in the following order. The first segment discusses demographic data of the nurses surveyed. This background information included five items that may have affected opinions the nurses had about health services for minors.

Following demographic data is information concerning nurses' opinions of the advisability, availability, and minors' awareness of the availability of health services for minors without parental consent. Frequencies and percentages of responses to items on a Likert-type scale are presented in this section.

Nurses' perceptions of the impacts of Oklahoma law regarding health services for minors without parental consent are presented next. This section also includes nurses' opinions concerning the need for a change in Oklahoma law, a discussion of changes some of them believed should be made, and reasons why they believed this way.

The final portion of this chapter presents results of chi square tests relating to the variables of study. Response comparisons included nurses' beliefs concerning the advisability, availability, and

minors' knowledge of the availability of health services for minors without parental consent. Differences relating to advisability, availability, and minors' knowledge of availability were also tested for the number of years the respondents had worked in health services, the number of years they had worked in their present communities, the state planning district in which they were employed, their direct provision of health services for minors, and their current fields of employment.

In this chapter, names of the major variables are shortened to facilitate ease of discussion. Nurses' opinions of the advisability of health services for minors in Oklahoma without parental consent will be referred to as "advisability", nurses' opinions of the availability of health services for minors in Oklahoma without parental consent will be referred to as "availability", and nurses' opinions of minors' knowledge of the availability of services for minors in Oklahoma without parental consent will be referred to as "minors' knowledge".

Demographic Data

The 199 registered nurses who participated in the study are discussed below and described in Tables II through VIII. The first personal response requested from them was the number of years they had worked in health services. Years nurses had worked were grouped into five year increments for analysis. As is shown in Table II, over 62 percent of the 187 nurses who responded to this item had worked in health services for 15 years or less. Twenty-five percent had been employed in health services for 6 to 10 years. Twenty percent of the nurses had worked five years or less and 16 percent had worked 11 to 15

TABLE II

NUMBER OF YEARS NURSES HAVE
WORKED IN HEALTH SERVICES
(N = 187)

Years	Frequency	Percent
0 - 5	39	20.86
6 - 10	47	25.13
11 - 15	30	16.04
16 - 20	23	12.30
21 - 25	13	6.95
26 - 30	15	8.02
31 or more	20	10.70
Total	187	100.00

years. Over one-half had worked more than 10 years and over 10 percent had been employed in health services for more than 30 years.

The nurses completing this survey were not long-time health service employees in their present communities. Almost one-half of the respondents had worked in their present communities for five years or less (Table III). Nearly three-fourths of them had worked there for 10 years or less. Only seven percent of the nurses who responded had been employed in their present communities for more than 20 years.

Table IV lists the state planning districts, counties included in each district, and number of nurses who participated in the survey from each district. More than one-third of the participants were employed in District VIII. Located in this district is the Oklahoma City area which includes several large medical centers, the University of Oklahoma College of Medicine, and the Oklahoma State Department of Health. The second largest representation was from District VI, another metropolitan area which includes Tulsa. The most sparsely populated district was District XI. None of the four questionnaires sent to nurses in the northwest and panhandle area were returned. (For information regarding the distribution of the sample, see Appendix C.)

There was approximately five percent difference in the number of nurses who did and did not provide health services directly to minors (Table V). Of the 180 nurses who responded to this item, 85 provided direct services and 95 did not.

A majority of the nurses who participated in the study were working in hospitals (Table VI). The 112 who identified "hospital" as the position of employment were 56 percent of the 220 total positions represented by the 195 nurses who responded. Nurses were requested to

TABLE III

NUMBER OF YEARS NURSES HAVE
WORKED IN COMMUNITY
(N = 185)

Years	Frequency	Percent
0 - 5	89	48.11
6 - 10	49	26.49
11 - 15	21	11.35
16 - 20	12	6.49
21 - 25	7	3.78
26 - 30	5	2.70
31 or more	2	1.08
Total	185	100.00

TABLE IV

DISTRIBUTION OF NURSES BY STATE PLANNING DISTRICTS
(N = 186)

Planning District	Counties	Frequency
I	Ottawa, Craig, Delaware, Mayes, Rogers, Nowata, Washington	17
II	Adair, Cherokee, Sequoyah, Muskogee, McIntosh, Okmulgee, Wagoner	16
III	McCurtain, Leflore, Latimer, Haskell, Pittsburg, Pushmataha, Choctaw	9
IV	Bryan, Love, Marshall, Murray, Coal, Atoka, Garvin, Johnston, Carter, Pontotoc	10
V	Pottawatomie, Seminole, Hughes, Okfuskee, Lincoln, Payne, Pawnee	11
VI	Creek, Tulsa, Osage	32
VII	Kingfisher, Blaine, Garfield, Noble, Kay, Grant, Alfalfa, Major	12
VIII	Canadian, Logan, Oklahoma, Cleveland	68
IX	Caddo, Grady, Comanche, Tillman, Cotton, Jefferson, Stephens, McClain	16
X	Custer, Roger Mills, Beckham, Washita, Green, Jackson, Harmon, Kiowa	6
XI	Woodward, Ellis, Harper, Beaver, Texas, Cimarron, Woods, Dewey	0
Total		197[1]

[1]Frequency responses total more than the actual number of respondents because some nurses worked in more than one district.

TABLE V

NURSES' INVOLVEMENT IN THE PROVISION OF HEALTH SERVICES TO MINORS (N = 180)

Response	Frequency	Percent
Services are provided to minors	85	47.22
Services are not provided to minors	95	52.78
Total	180	100.00

TABLE VI

NURSES' CURRENT FIELD OF EMPLOYMENT
(N = 195)

Types of Employment	Response	
	Frequency	Percent
Hospital	112	56.28
Nursing Home	10	5.03
School of Nursing	11	5.53
Private Duty	5	2.51
Public Health	11	5.53
School Nurse	8	4.02
Industrial Nurse	4	2.01
Office Nurse	11	5.53
Other	48	24.12
Total	220	110.56[1]

[1]Totals equal more than 100% because respondents were requested to check as many types of employment as applied.

check more than one field of employment if they worked in more than one place. Of the fields of employment listed, four were each identified by approximately five percent of the nurses. These four fields were nursing homes (5.03 percent), schools of nursing (5.53 percent), public health (5.53 percent), and physicians' offices (5.53 percent). Nearly 25 percent of the nurses were employed in fields other than those listed in the categories specified by the Oklahoma State Department of Health.

Table VII lists the write-in responses from nurses who did not work in categories identified on the questionnaire. Of the 48 written responses, 16 were from nurses who were unemployed. Another seven nurses considered themselves retired. Of the remaining written respondents, 10 were community nurses, six were teaching or attending school, and the rest described themselves as a consultant, nurse practitioner, physicians' assistant, nursing specialists, or psychiatry-related nurses.

Chi square tests were used to determine if a relationship existed between the nurses' field of employment and whether they were direct providers of health services for minors (Table VIII). The areas of employment listed were hospital, nursing home, school of nursing, private duty, public health, school nurse, industrial nurse, and office nurse. A space was supplied for respondents to include other fields of employment. When nurses employed in nursing homes were compared with all other nurses significance was found ($\underline{p} < .05$). Significance ($\underline{p} < .05$) was also found for nurses employed in schools of nursing. Nurses in these employment locations were less likely than others to provide services for minors. A significant relationship

TABLE VII

NURSES' WRITTEN RESPONSES TO THE ITEM RELATING TO OTHER FIELDS OF EMPLOYMENT
(N = 48)

Field of Employment	Frequency
Community nursing[1]	10
College or other school	6
Consultant	1
Nurse practitioner	1
Physician's assistant	1
Psychiatry-related occupation	2
Nursing specialist	4
Unemployed	16
Retired	7
Total	48

[1]Nurses who were grouped into community nursing included those who listed Red Cross, family planning, child abuse clinic, abortion clinic, childbirth and parent education, mental health, health care office, and public agencies.

TABLE VIII

SUMMARY OF CHI SQUARE TESTS OF DIRECT PROVISION OF SERVICES BY CURRENT FIELD OF EMPLOYMENT (N = 183)[1]

Field of Employment	Chi Square Value	Degrees of Freedom	Probability
Hospital	4.87	2	0.0875
Nursing Home	9.14	2	0.0103
School of Nursing	10.84	2	0.0044
Private Duty	1.64	2	0.4405
Public Health	5.91	2	0.0521
School Nurse	2.77	2	0.2500
Industrial Nurse	0.89	2	0.6402
Office Nurse	4.81	2	0.0902
Other	5.12	2	0.0771

[1]This number represents total respondents to the items. The number of respondents for each category of employment varied. See Tables VI and VII for field of employment of respondents.

between the field of employment and direct provision of health services was not found for the other employment locations.

Summary of Demographic Characteristics

Responses regarding demographic factors showed that the majority of nurses had worked in health services for 15 years or less and nearly three-fourths of them had worked in their present communities for 10 years or less. Metropolitan areas had the largest number of nurses responding. Forty-seven percent of the nurses provided direct services while 53 percent did not. A majority of the nurses worked in hospitals. Nurses who worked in nursing homes and schools of nursing were significantly different from other nurses regarding direct provision of services to minors.

Opinions Regarding Advisability, Availability, and Minors' Knowledge

Table IX presents opinions of nurses concerning the advisability of providing health services for minors in Oklahoma without parental consent. Of the 10 services listed, the nurses' responses were more similar regarding sterilization than any other service. Of the nurses responding to this item, 111 (58 percent) strongly disagreed that it should be available to minors without parental consent. Another 49 respondents (26 percent) disagreed that it should be available.

Treatment for pustular acne was another service to which a majority of nurses responded in a similar manner. Eighty-three persons, (43 percent) agreed that pustular acne treatment should be available and an additional 55 (29 percent) strongly agreed that such

TABLE IX

NURSES' OPINIONS ON THE ADVISABILITY OF HEALTH SERVICES FOR MINORS IN OKLAHOMA WITHOUT PARENTAL CONSENT

Service	Responses to Services Should Be Available									
	Undecided		Strongly Disagree		Disagree		Agree		Strongly Agree	
	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent
Treatment for Pustular Acne	7	3.67	12	6.28	34	17.80	83	43.46	55	28.80
Treatment for Menstrual Problems	8	4.21	19	10.00	49	25.79	75	39.47	39	20.53
Contraceptive Services	9	4.76	35	18.52	32	16.93	65	34.39	48	25.40
Treatment for Venereal Disease	4	2.13	28	14.89	17	9.04	66	35.11	73	38.83
Abortion Services	23	12.04	72	37.70	53	27.75	26	13.61	17	8.90
Treatment for Obesity	9	4.69	13	6.77	50	26.04	74	38.54	46	23.96
Sterilization Services	13	6.81	111	58.12	49	25.65	10	5.24	8	4.19
Pelvic Examinations	6	3.16	30	15.79	30	15.79	71	37.37	53	27.90
Pregnancy Testing	3	1.59	26	13.76	23	12.17	78	41.27	59	31.22
Breast Examinations	4	2.13	18	9.57	26	13.83	80	42.55	60	31.92

[1]The greatest number responding to this section was 192, however, not all participants responded to all items. Percentages are based on the number responding to specific services.

treatment should be possible.

Almost the same number of nurses (43 percent agree, 32 percent strongly agree) responded positively concerning the advisability of breast examinations for minors without parental consent and pregnancy testing (41 percent agreed, 31 percent strongly agreed). Four percent more nurses strongly agreed that pregnancy testing should be available than believed breast examinations should be.

The nurses most strongly agreed that treatment for venereal disease should be available. Seventy-three (39 percent) of the respondents were in strong agreement that this service should be provided. Sixty-six (35 percent) more nurses agreed that is should be available. Less than one-fourth of the participants believed that treatment for venereal disease should not be provided to minors without their parents' consent.

The health professionals surveyed were most undecided concerning the advisability of abortions without parental consent. There were 23 respondents (12 percent) undecided on this issue. Sterilization services had 13 respondents (almost seven percent) who were undecided concerning its advisability. The only two services for which a majority of the nurses disagreed with the advisability of its being available to minors were abortions and sterilization, the two that also received the most undecided responses.

Nurses who disagreed with the advisability of services responded more strongly on services that were associated with sexual behavior than on services that were not associated with sexual behavior. The percentage of nurses who strongly disagreed was greater than those who disagreed on contraceptive services, treatment for venereal disease,

abortion services, sterilization services, and pregnancy testing. These were the five services related to sexual behavior that were included in the questionnaire. The only item in which strongly agree was checked more often than agree was treatment for venereal disease, a service related to sexual behavior. Over one-half of the respondents were so sure of their beliefs that they responded in the strongly agree or strongly disagree column for venereal disease treatment.

Although fewer nurses responded to the items assessing availability, a considerably larger number were undecided concerning what services were actually available (Table X). Over one-fourth of the respondents were undecided if treatment for pustular acne, treatment for menstrual problems, abortion services, treatment for obesity, and sterilization services were available for minors without parental consent. Almost one-third of the respondents were undecided about treatment for pustular acne.

Forty-nine percent of the nurses agreed that pregnancy testing was available. Thirteen percent (23 nurses) strongly agreed that it was available. There were fewer nurses (31) who were undecided about the availability of pregnancy testing than there were for any other service.

Respondents were most in agreement in their belief that sterilization services were not available to minors in Oklahoma without parental consent. Only 10 nurses (6 percent) believed sterilization services were available while 61 (35 percent) disagreed and 56 (32 percent) strongly disagreed that services were available.

Nurses' responses to items regarding the availability of health services for minors in Oklahoma were less adamant than were their responses concerning advisability. On these items they checked agree or

TABLE X

NURSES' OPINIONS ON THE AVAILABILITY OF HEALTH SERVICES FOR MINORS IN OKLAHOMA WITHOUT PARENTAL CONSENT

Service	Responses to Services Are Available									
	Undecided		Strongly Disagree		Disagree		Agree		Strongly Agree	
	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent
Treatment for Pustular Acne	57	32.95	14	8.09	28	16.19	60	34.68	14	8.09
Treatment for Menstrual Problems	44	25.14	13	7.43	36	20.57	70	40.00	12	6.86
Contraceptive Services	36	20.57	20	11.43	34	19.43	72	41.14	13	7.43
Treatment for Venereal Disease	33	18.64	12	6.78	25	14.12	75	42.37	32	18.08
Abortion Services	47	26.71	27	15.34	58	32.96	34	19.32	10	5.68
Treatment for Obesity	49	28.32	11	6.36	42	24.28	57	32.95	14	8.09
Sterilization Services	48	27.43	56	32.00	61	34.86	7	4.00	3	1.71
Pelvic Examinations	33	19.08	16	9.25	34	19.65	73	42.20	17	9.83
Pregnancy Testing	31	17.61	13	7.39	22	12.50	87	49.43	23	13.07
Breast Examinations	41	23.30	13	7.39	24	13.64	79	44.87	19	10.80

[1]The greatest number responding to this section was 176, however, not all participants responded to all items. Percentages are based on the number responding to specific services.

disagree more frequently than strongly agree or strongly disagree. For each item, the more moderate responses had higher frequencies.

Table XI presents nurses' opinions concerning minors' knowledge of health services available to minors in Oklahoma without parental consent. Responses show that nurses did not have strong beliefs regarding minors' awareness of services that were available to them without parental consent. For each item the agree and disagree response was greater than strongly agree and strongly disagree.

Data presented in Table XI indicated that many of the nurses were undecided about what health services they believed minors knew were available to them. Over one-fourth of the respondents were undecided for acne treatment, treatment for menstrual problems, abortion services, obesity treatment, and sterilization services. For each of the remaining services approximately one-fifth of the respondents were undecided.

Of the 178 participants who responded to at least part of these items, 70 (40 percent) nurses agreed that minors knew pregnancy testing was available. The second highest frequency on a single item was 66 (38 percent). These nurses disagreed that minors knew that sterilization services were available to them without parental consent. Other services that had responses from 50 or more nurses who disagreed that adolescents knew the service was available were acne treatment (31 percent), treatment for menstrual problems (32 percent), abortion services (32 percent), obesity treatment (33 percent), and pelvic examinations (32 percent). Thirty percent strongly disagreed that adolescents were aware of sterilization services.

TABLE XI

NURSES' OPINIONS ON MINORS' KNOWLEDGE OF THE AVAILABILITY OF HEALTH SERVICES WITHOUT PARENTAL CONSENT

Services	Responses to Minors' Know Services are Available									
	Undecided		Strongly Disagree		Disagree		Agree		Strongly Agree	
	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent
Treatment for Pustular Acne	56	32.37	16	9.25	54	31.21	33	19.08	14	8.09
Treatment for Menstrual Problems	46	26.14	17	9.66	56	31.82	46	26.14	11	6.25
Contraceptive Services	38	21.35	24	13.48	49	27.53	54	30.34	13	7.30
Treatment for Venereal Disease	36	20.34	18	10.17	46	25.99	50	28.25	27	15.25
Abortion Services	47	26.86	31	17.71	56	32.00	32	18.29	9	5.14
Treatment for Obesity	48	27.43	16	9.14	58	33.14	41	23.43	12	6.86
Sterilization Services	46	26.29	52	29.71	66	37.71	7	4.00	4	2.29
Pelvic Examinations	41	23.30	19	10.80	56	31.82	44	25.00	16	9.09
Pregnancy Testing	38	21.59	15	8.52	38	21.59	70	39.77	15	8.52
Breast Examinations	42	24.14	15	8.62	48	27.59	51	29.31	18	10.35

[1]The greatest number responding to this section was 178, however, not all participants responded to all items. Percentages are based on the number responding to specific services.

There were three areas other than pregnancy testing where 50 or more nurses agreed that services were available to minors in Oklahoma without parental consent. Contraceptive services (30 percent), venereal disease treatment (28 percent), and breast examinations (29 percent) were the highest frequencies other than pregnancy testing.

Table XII presents a comparison of nurses' opinions of the 10 health services' advisability, availability, and minors' knowledge of the availability to them in Oklahoma without parental consent. The figures in this table were obtained by collapsing percentage data into two groups combining the percentages of agree and strongly agree and disagree and strongly disagree.

A majority of the participants agreed that eight of the services should be available to minors without parental consent. Abortion services and sterilization services were the only services that a majority of participating nurses did not believe should be available. Fewer than one-fourth of the respondents believed that treatment for pustular acne, treatment for venereal disease, and breast examinations should not be available to minors in Oklahoma without parental consent. Twenty-six percent of the nurses did not believe pregnancy testing should be available and approximately one-third did not want services for menstrual problems, contraception, obesity, and pelvic examinations to be available.

There were four services that a majority of nurses believed were available for minors without parental consent. Treatment for venereal disease (60 percent), pelvic examinations (52 percent), pregnancy testing (63 percent), and breast examinations (56 percent) were believed by over half of the nurses to be available. A majority (67

TABLE XII

NURSES' OPINIONS OF WHETHER HEALTH SERVICES FOR MINORS IN OKLAHOMA SHOULD BE AVAILABLE, ARE AVAILABLE, AND ARE KNOWN BY MINORS TO BE AVAILABLE WITHOUT PARENTAL CONSENT[1] (N = 199)[2]

Service	Response					
	Service Should Be Available		Service Is Available		Adolescents Know If Service Is Available	
	Percent[3] Agree	Percent Disagree	Percent Agree	Percent Disagree	Percent Agree	Percent Disagree
Treatment for Pustular Acne	72.25	24.08	42.77	24.28	27.17	40.46
Treatment for Menstrual Problems	60.00	35.79	46.86	28.00	32.39	41.47
Contraceptive Services	59.79	35.45	48.57	30.86	37.64	41.01
Treatment for Venereal Disease	73.94	23.94	60.45	20.90	43.50	36.15
Abortion Services	22.51	65.45	25.00	48.30	23.43	49.71
Treatment for Obesity	62.50	32.81	41.04	30.64	30.29	42.28
Sterilization Services	9.42	83.77	5.71	66.86	6.29	67.42
Pelvic Examinations	65.26	31.58	52.02	28.90	34.09	42.62
Pregnancy Testing	72.49	25.93	62.50	19.89	48.29	30.11
Breast Examinations	74.47	23.40	55.68	21.53	39.66	36.21

[1]Data were collasped into two groups combining strongly agree and agree and strongly disagree and disagree. Undecideds were omitted in this table.

[2]Some items were not answered by all respondents.

[3]This table contains percentages only. Frequencies are included in Tables IX, X, and XI.

percent) of the respondents disagreed that sterilization services were available for minors in Oklahoma without parental consent. A higher percentage of nurses agreed services were available than disagreed they were available for all services except abortion services and sterilization services.

Sixty-seven percent of the respondents were of the opinion that minors had no knowledge of the availability of sterilization services without parental consent. This was the only service on which a majority of the nurses agreed. More nurses agreed than disagreed that minors knew of the availability of treatment for venereal disease (44 percent), pregnancy testing (48 percent), and breast examinations (40 percent). For all other services the greater percentage of nurses disagreed that minors knew they could obtain the services without parental consent.

Opinions Regarding Impacts of Oklahoma Law

A review of Oklahoma state law 63 O.S., Sections 2601-2602 preceded the section of the questionnaire concerning the nurses' perceptions of the impacts of Oklahoma law regarding health services for minors. Table XIII presents perceptions nurses had about how the law had affected six possible areas of concern.

A majority (61 percent) of the nurses who responded to Part II of the questionnaire believed that under the existing Oklahoma law there had been an increase in early contact with health professionals by pregnant minors, and 64 percent believed there had been an increase in lawful abortions by minors. Although it was not a majority, 79 respondents (42 percent) believed that under the existing law there had been

TABLE XIII

NURSES' PERCEPTIONS OF THE IMPACTS OF OKLAHOMA LAW REGARDING HEALTH SERVICES FOR MINORS WITHOUT PARENTAL CONSENT (N = 189)[1]

Impact	Response					
	Increase		No Impact		Decrease	
	Frequency	Percent	Frequency	Percent	Frequency	Percent
Early contact with health professionals by pregnant minor	116	61.38	45	23.81	28	14.82
Repeat pregnancies by minors	79	41.80	65	34.39	45	23.81
Unlawful abortions by minors	67	35.64	48	25.53	73	38.83
Lawful abortions by minors	120	64.17	39	20.86	28	14.97
First pregnancies by minors	67	35.64	89	47.34	32	17.02
Health risks incurred by minors	65	34.57	50	26.60	73	38.83

[1]The greatest number responding to this section was 189, however, not all participants responded to all items. Percentages are based on the number responding to specific impacts.

an increase in repeat pregnancies. Eighty-nine respondents (47 percent) believed the law had no impact on first pregnancies by minors, 73 nurses (39 percent) believed the law was associated with a decrease in unlawful abortions by minors, and 73 nurses (39 percent) believed the impact of the law had been a decrease in health risks incurred by minors. Under the existing law, more nurses believed there had been an increase in first and repeat pregnancies than believed there had been a decrease in them.

There were 163 nurses who expressed an opinion in Part III of the questionnaire concerning the need for a change in Oklahoma law regarding health services for minors. Seventy-one percent of the respondents believed the law should be changed while 29 percent wanted the law to remain the same (Table XIV).

Table XV provides a summary of changes respondents wanted in the law. Of the 109 nurses responding to this short-answer item, 45 (41 percent) wanted the law to become more liberal compared to 19 (17 percent) who preferred it become more conservative. Several nurses (19 percent) indicated a desire for increased education for minors and 10 percent wanted counseling provided.

Reasons for desiring changes in the law were listed by 84 respondents (Table XVI). Not all nurses desired change and of the ones who did, not all listed a reason. The most frequently given reason for wanting a change was to prevent unwanted pregnancy (16). Other reasons given by several nurses were to provide children with information not provided by parents (13), to encourage earlier and better health care (11), and to insure parental responsibility (8). The rest of the 23 responses given were each mentioned by 5 or fewer respondents.

TABLE XIV

NURSES' OPINIONS CONCERNING NEED FOR CHANGE IN OKLAHOMA LAW REGARDING HEALTH SERVICES FOR MINORS (N = 163)

Response	Frequency	Percent
The law should be changed	115	70.55
The law should not be changed	48	29.45
Total	163	100.00

TABLE XV

CHANGES IN OKLAHOMA LAW REGARDING HEALTH SERVICES FOR MINORS RECOMMENDED BY NURSES (N = 109)[1]

Responses	Frequency	Percent
Make law more conservative[2]	19	17.43
Make law more liberal[3]	45	41.28
Increase education	21	19.27
Provide counseling	11	10.09
Make law plainer and better known	6	5.50
Determine financing responsibility	4	3.67
Address minor's child	1	0.92
Unrelated[4]	2	1.83
Total	109	99.99

[1]Only the respondents who wanted a change in the law responded to this question. Not all of the 115 desiring a change responded.

[2]Conservative changes included requiring complete parental knowledge, protecting family unit, and preventing abortion without parental consent.

[3]Liberal changes included giving contraceptives to minors, providing equal services for minors, providing some or all professional services for minors, and lowering the legal age for consent for health problem treatment.

[4]The unrelated suggestions pertained to records of adopted children and a need for mental health provisions.

TABLE XIV

REASONS FOR CHANGES IN LAW CONCERNING HEALTH SERVICES FOR MINORS RECOMMENDED BY NURSES (N = 84)[1]

Reason	Frequency
Prevent unwanted pregnancy	16
Provide children with information not provided by parents	13
Encourage earlier and better health care	11
Insure parental responsibility	8
Allow adolescent to have some decision making responsibility	5
Reduce teen health problems	5
Reduce venereal disease	4
Provide adult input	2
Reduce repeat pregnancies	2
Permit equality	2
Reduce child abuse/neglect	2
Improve trust and communication with parents	2
Insure legal support	2
Reduce abortions	1
Prevent emergency delays	1
Assist minor before pregnancy	1
Obey Bible	1
Improve infant health	1
Protect minors	1
Reflect laws in other states	1
Reduce sexual activity	1
Encourage emotional stability	1
Encourage healthy futures	1
Total	84

[1]This represents the number responding to this item. Not all nurses desired or listed changes or reasons for changes.

Opinions Regarding Health Services for Minors

Advisability and Availability of Health Services

Comparisons of nurses' responses regarding health services they believed should be available and those they believed were available to minors in Oklahoma without parental consent are presented in Table XVII. A significant difference ($p < .05$) was indicated for each of the 10 services tested. Generally, the data indicated that nurses preferred more services to be available than were actually available.

Advisability and Minors' Knowledge

As reported in Table XVIII, there were no significant differences found when testing the advisability of services relating to contraception and the advisability of services relating to venereal disease by what nurses believed minors knew of the availability of each of these services. Significant differences ($p < .05$) were found in services relating to acne, menstruation, abortion, obesity, sterilization, pelvic examinations, pregnancy testing, and breast examinations.

Availability and Minors' Knowledge

Significant differences at the $p < .05$ level were indicated for all services regarding those nurses believed were available to minors in Oklahoma without parental consent and what they believed minors knew were available to them (Table XIX). More than 60 percent of the nurses who believed a service was available also believed minors knew the service was available.

TABLE XVII

SUMMARY OF CHI SQUARE TESTS OF SERVICES NURSES BELIEVE SHOULD BE AVAILABLE BY SERVICES THEY BELIEVE ARE AVAILABLE

Service	N	Chi Square Value	Degrees of Freedom	Probability
Treatment for pustular acne	171	37.66	4	0.0001
Treatment for menstrual problems	174	28.79	4	0.0001
Contraceptive services	173	11.93	4	0.0179
Treatment for venereal disease	174	19.69	4	0.0006
Abortion services	175	32.18	4	0.0001
Treatment for obesity	173	45.92	4	0.0001
Sterilization services	173	43.90	4	0.0001
Pelvic examinations	172	31.52	4	0.0001
Pregnancy testing	174	36.93	4	0.0001
Breast examinations	172	37.63	4	0.0001

TABLE XVIII

SUMMARY OF CHI SQUARE TESTS OF SERVICES NURSES BELIEVE SHOULD BE AVAILABLE BY SERVICES THEY BELIEVE MINORS KNOW ARE AVAILABLE

Service	N	Chi Square Value	Degrees of Freedom	Probability
Treatment for pustular acne	171	15.29	4	0.0041
Treatment for menstrual problems	174	21.94	4	0.0002
Contraceptive services	174	4.17	4	0.3836
Treatment for venereal disease	173	9.24	4	0.0555
Abortion services	173	10.72	4	0.0298
Treatment for obesity	173	29.70	4	0.0001
Sterilization services	173	34.07	4	0.0001
Pelvic examinations	173	16.18	4	0.0028
Pregnancy testing	173	15.71	4	0.0034
Breast examinations	170	11.13	4	0.0251

TABLE XIX

SUMMARY OF CHI SQUARE TESTS OF SERVICES NURSES BELIEVE ARE AVAILABLE BY SERVICES THEY BELIEVE MINORS KNOW ARE AVAILABLE

Service	N	Chi Square Value	Degrees of Freedom	Probability
Treatment for pustular acne	168	142.78	4	0.0001
Treatment for menstrual problems	171	170.70	4	0.0001
Contraceptive services	173	182.99	4	0.0001
Treatment for venereal disease	173	125.69	4	0.0001
Abortion services	172	199.63	4	0.0001
Treatment for obesity	171	177.60	4	0.0001
Sterilization services	173	165.02	4	0.0001
Pelvic examinations	171	149.80	4	0.0001
Pregnancy testing	172	172.16	4	0.0001
Breast examinations	171	137.63	4	0.0001

Summary

In chi square tests of differences in the advisability and availability of 10 health services of interest to minors in Oklahoma without parental consent, it was indicated that there was a relationship between services nurses believed should be available and services they believed were available. For the services related to acne, menstruation, abortion, obesity, pelvic examinations, pregnancy testing, and breast examinations, significance was found between responses regarding advisability and minors' knowledge of the services. No significant differences related to nurses' beliefs of advisability and their beliefs regarding minors' knowledge of services were indicated for services relating to contraception, sterilization, and venereal disease. Data reporting differences between nurses' beliefs regarding availability of services and minor's knowledge of services were significant for all 10 services.

Relationship Between Number of Years Nurses Have Worked in Health Services and Advisability, Availability, and Minors' Knowledge of Health Services

Number of Years Worked and Advisability

Years nurses had worked in health services were grouped into increments of five years with the final increment being 30 years or more. No significant differences were found when testing the number of years nurses have worked in health services by services they

believed should be available (Table XX). Generally, the nurses who had worked more than 30 years were less likely to favor providing the service without parental consent. There were no significant differences in the number of years nurses had worked for services relating to contraception, venereal disease, abortion, obesity, sterilization, pelvic examinations, pregnancy testing, or breast examinations.

Number of Years Worked and Availability

As noted in Table XXI, the data indicated no significant differences in nurses' beliefs regarding the availability of the 10 health services for minors in Oklahoma without parental consent associated with the number of years the respondents had worked in health services. Between 168 and 172 nurses completed the items on this part of the questionnaire.

Number of Years Worked and Minors' Knowledge

No significant differences were found when testing the number of years nurses had been employed in health services by their beliefs regarding what minors knew of service availability (Table XXII). It appeared that nurses' opinions of minors' knowledge of the availability of services was unrelated to their years of experience in health services. Since March, 1971, treatment for venereal disease has been available without parental consent for Oklahoma minors (Sixty-three, O.S., 1971), however, the years of working under that law apparently had no effect on nurses' beliefs.

TABLE XX

SUMMARY OF CHI SQUARE TESTS OF NUMBER OF YEARS NURSES HAVE WORKED IN HEALTH SERVICES BY SERVICES THEY BELIEVE SHOULD BE AVAILABLE

Service	N	Chi Square Value	Degrees of Freedom	Probability
Treatment for pustular acne	184	21.20	12	0.0476
Treatment for menstrual problems	183	21.88	12	0.0389
Contraceptive services	182	10.27	12	0.5926
Treatment for venereal disease	181	12.20	12	0.4296
Abortion services	184	9.03	12	0.7001
Treatment for obesity	185	13.57	12	0.3292
Sterilization services	184	11.80	12	0.4622
Pelvic examinations	183	11.51	12	0.4855
Pregnancy testing	182	13.38	12	0.3423
Breast examinations	181	15.92	12	0.1948

TABLE XXI

SUMMARY OF CHI SQUARE TESTS OF NUMBER OF YEARS NURSES HAVE WORKED IN HEALTH SERVICES BY SERVICES THEY BELIEVE ARE AVAILABLE

Service	N	Chi Square Value	Degrees of Freedom	Probability
Treatment for pustular acne	168	9.28	12	0.6787
Treatment for menstrual problems	170	6.69	12	0.8776
Contraceptive services	170	12.16	12	0.4330
Treatment for venereal disease	172	17.60	12	0.1282
Abortion services	171	8.34	12	0.7580
Treatment for obesity	169	8.01	12	0.7841
Sterilization services	171	8.48	12	0.7462
Pelvic examinations	169	9.81	12	0.6324
Pregnancy testing	172	7.52	12	0.8218
Breast examinations	172	10.66	12	0.5583

TABLE XXII

SUMMARY OF CHI SQUARE TESTS OF NUMBER OF YEARS NURSES HAVE WORKED IN HEALTH SERVICES BY SERVICES THEY BELIEVE MINORS KNOW ARE AVAILABLE

Service	N	Chi Square Value	Degrees of Freedom	Probability
Treatment for pustular acne	168	9.00	12	0.7027
Treatment for menstrual problems	171	10.65	12	0.5592
Contraceptive services	173	9.70	12	0.6424
Treatment for venereal disease	172	20.59	12	0.0567
Abortion services	170	9.22	12	0.6838
Treatment for obesity	171	11.32	12	0.5018
Sterilization services	171	12.47	12	0.4087
Pelvic examinations	172	9.98	12	0.6174
Pregnancy testing	172	14.27	12	0.2838
Breast examinations	170	16.38	12	0.1745

Summary of Number of Years Nurses Have Worked By Advisability, Availability, and Minors' Knowledge

No differences were indicated between the number of years nurses had worked and their opinions toward the advisability of health services for minors without parental consent. The number of years nurses had worked in health services was of no significant difference in their beliefs concerning the availability of health services or their opinions of minors' knowledge of services availability.

Relationship Between Number of Years Nurses Have Worked in Present Communities By Their Opinions Concerning Health Services

Number of Years in Community By Advisability

Years nurses had worked in health services in their present communities were grouped into the same increments as the number of years they had worked in health services. Increments of five years were used with the final group being those employed in their communities for 30 years or more.

Although significance was found when testing advisability of treatment for menstrual problems, abortion services, treatment for obesity, pelvic examinations, and pregnancy testing by the number of years nurses had worked in their present communities (Table XXIII); warnings were noted. After careful examination of the contingency tables, the researcher concluded that due to sparsity within the cells

TABLE XXIII

SUMMARY OF CHI SQUARE TESTS OF NUMBER OF YEARS NURSES HAVE WORKED IN THEIR PRESENT COMMUNITIES BY SERVICES THEY BELIEVE SHOULD BE AVAILABLE

Service	N	Chi Square Value	Degrees of Freedom	Probability
Treatment for pustular acne	182	20.49	12	0.0583
Treatment for menstrual problems	181	25.79	12	0.0115[1]
Contraceptive services	180	10.26	12	0.5932
Treatment for venereal disease	179	8.95	12	0.7068
Abortion services	182	22.52	12	0.0321[1]
Treatment for obesity	183	24.32	12	0.0184[1]
Sterilization services	182	11.16	12	0.5153
Pelvic examinations	181	22.92	12	0.0284[1]
Pregnancy testing	180	23.84	12	0.0214[1]
Breast examinations	179	10.07	12	0.6100

[1]Over 20 percent of the cells had expected counts of less than five. Table was so sparse that chi square may not be a valid test.

the chi square tests may have been inappropriate.

Number of Years in Community By Availability

When testing responses on number of years nurses had worked in their present communities by the services they believed were available there were no significant results (Table XXIV). Although significance was not obtained, it may be generally noted that nurses who had worked in their communities over 15 years were less likely to believe that health services were available to minors in Oklahoma without parental consent.

Number of Years in Community By Minors' Knowledge

Due to the sparsity within the cells, the chi square tests of number of years nurses had been employed in the community by minors' knowledge were judged to be invalid (Table XXV).

Summary of Number of Years Nurses Have Worked in Present Communities By Their Opinions of Health Services

There were no significant differences found for the advisability, availability, or minors' knowledge of any services associated with the number of years nurses had worked in their present communities. The occurrence of expected values less than five in numerous cells of the contingency tables caused the researcher to view the tests as invalid.

TABLE XXIV

SUMMARY OF CHI SQUARE TESTS OF NUMBER OF YEARS NURSES HAVE WORKED IN THEIR PRESENT COMMUNITIES BY SERVICES THEY BELIEVE ARE AVAILABLE

Service	N	Chi Square Value	Degrees of Freedom	Probability
Treatment for pustular acne	166	13.51	12	0.3330
Treatment for menstrual problems	168	15.69	12	0.2059
Contraceptive services	168	16.50	12	0.1692
Treatment for venereal disease	170	14.30	12	0.2817
Abortion services	169	11.78	12	0.4635
Treatment for obesity	167	15.76	12	0.2022
Sterilization services	169	14.34	12	0.2796
Pelvic examinations	167	21.06	12	0.0496[1]
Pregnancy testing	170	16.12	12	0.1857
Breast examinations	170	20.60	12	0.0566

[1]Over 20 percent of the cells had expected counts less than five. Table was so sparse that chi square may not be a valid test.

TABLE XXV

SUMMARY OF CHI SQUARE TESTS OF NUMBER OF YEARS NURSES HAVE WORKED IN THEIR PRESENT COMMUNITIES BY SERVICES THEY BELIEVE MINORS KNOW ARE AVAILABLE

Service	N	Chi Square Value	Degrees of Freedom	Probability
Treatment for pustular acne	166	16.46	12	0.1713
Treatment for menstrual problems	169	14.59	12	0.2644
Contraceptive services	171	17.73	12	0.1241
Treatment for venereal disease	170	14.33	12	0.2802
Abortion services	168	14.12	12	0.2932
Treatment for obesity	169	16.33	12	0.1765
Sterilization services	169	19.56	12	0.0759
Pelvic examinations	170	16.78	12	0.1581
Pregnancy testing	170	22.14	12	0.0360[1]
Breast examinations	168	14.60	12	0.2639

[1]Over 20 percent of the cells had expected counts less than five. Table was so sparse that chi square may not be valid test.

Relationship Between Nurses' State Planning District of Employment and Their Opinions Concerning Health Services

State Planning District and Advisability

A presentation of the chi square values associated with the nurses' state planning districts and whether they believed health services of special interest to minors should be available without parental consent is presented in Table XXVI. No significant differences were found for any of the services except treatment for venereal disease; however, a warning is provided because of the sparsity of the responses in some of the cells.

Planning District and Availability

Based on the data from Table XXVII there is no reason to reject the null hypothesis stating that there are no differences in nurses' opinions of the availability of health services for minors without parental consent associated with geographic regions in which nurses worked. Probability values were greater than .05 for each of the 10 services.

Planning District and Minors' Knowledge

Data reporting the comparison of state planning districts and minors' knowledge of service availability are presented in Table XXVIII. No significant differences were indicated when state planning districts in which nurses worked were tested by their beliefs concerning whether minors knew of services available to them in Oklahoma without parental

TABLE XXVI

SUMMARY OF CHI SQUARE TESTS OF NURSES' STATE PLANNING DISTRICT BY SERVICES THEY BELIEVE SHOULD BE AVAILABLE

Service	N	Chi Square Value	Degrees of Freedom	Probability
Treatment for pustular acne	183	13.86	20	0.8374
Treatment for menstrual problems	182	17.10	20	0.6468
Contraceptive services	181	22.14	20	0.3327
Treatment for venereal disease	180	39.34	20	0.0061[1]
Abortion services	183	25.35	20	0.1882
Treatment for obesity	184	16.88	20	0.6611
Sterilization services	183	15.02	20	0.7756
Pelvic examinations	182	14.06	20	0.8275
Pregnancy testing	181	17.72	20	0.6059
Breast examinations	180	27.74	20	0.1157

[1]Over 20 percent of the cells had expected counts of less than five. Table was so sparse that chi square may not be a valid test.

TABLE XXVII

SUMMARY OF CHI SQUARE TESTS OF NURSES' STATE PLANNING DISTRICT BY SERVICES THEY BELIEVE ARE AVAILABLE

Service	N	Chi Square Value	Degrees of Freedom	Probability
Treatment for pustular acne	168	16.91	20	0.6587
Treatment for menstrual problems	169	14.78	20	0.7888
Contraceptive services	169	24.24	20	0.2318
Treatment for venereal disease	171	29.13	20	0.0853
Abortion services	170	13.89	20	0.8362
Treatment for obesity	168	16.21	20	0.7035
Sterilization services	170	13.65	20	0.8478
Pelvic examinations	168	16.26	20	0.7001
Pregnancy testing	171	12.15	20	0.9107
Breast examinations	171	14.12	20	0.8244

TABLE XXVIII

SUMMARY OF CHI SQUARE TESTS OF NURSES' STATE PLANNING DISTRICT BY SERVICES THEY BELIEVE MINORS KNOW ARE AVAILABLE

Service	N	Chi Square Value	Degrees of Freedom	Probability
Treatment for pustular acne	167	14.33	20	0.8132
Treatment for menstrual problems	170	13.67	20	0.8470
Contraceptive services	172	21.45	20	0.3711
Treatment for venereal disease	171	24.22	20	0.2328
Abortion services	169	14.44	20	0.8077
Treatment for obesity	170	27.64	20	0.1183
Sterilization services	170	10.26	20	0.9632
Pelvic examinations	171	19.01	20	0.5213
Pregnancy testing	171	19.32	20	0.5009
Breast examinations	169	13.67	20	0.8468

consent.

Summary of Nurses' State Planning District of Employment By Their Opinions Concerning Health Services

When the state planning district in which nurses worked was examined for its relationship to nurses' opinions regarding availability, advisability, and minors' knowledge of availability of health services without parental consent, no significant differences were found.

Relationship Between Nurses' Direct Provision of Services and Their Opinions Concerning Health Services

Direct Provision and Advisability

Table XXIX presents a summary of data concerning whether the beliefs nurses have regarding the advisability of health services for minors without parental consent are related to their participation in the direct provision of services for minors. No significant differences were found. Examinations of the contingency tables did indicate that nurses who directly provide health services for minors were more likely to agree that contraceptive services and treatment for venereal disease should be provided without parental consent.

Direct Provision and Availability

Direct provision of health services to minors by the responding

TABLE XXIX

SUMMARY OF CHI SQUARE TESTS OF NURSES' DIRECT PROVISION OF SERVICES BY SERVICES THEY BELIEVE SHOULD BE AVAILABLE

Service	N	Chi Square Value	Degrees of Freedom	Probability
Treatment for pustular acne	180	9.09	4	0.0590
Treatment for menstrual problems	179	6.78	4	0.1481
Contraceptive services	178	9.58	4	0.0481[1]
Treatment for venereal disease	177	18.38	4	0.0010[1]
Abortion services	180	3.64	4	0.4574
Treatment for obesity	181	5.42	4	0.2464
Sterilization services	180	0.82	4	0.9364
Pelvic examinations	179	7.40	4	0.1163
Pregnancy testing	178	3.60	4	0.4624
Breast examinations	177	2.11	4	0.7155

[1]Over 20 percent of the cells had expected counts of less than five. Table was so sparse that chi square may not be a valid test.

nurses was significantly related to their responses concerning the availability of the services in four areas (Table XXX). Contraceptive services, treatment for venereal disease, pelvic examinations, and pregnancy testing were all significant at $p < .05$. Contingency tables for the chi square analysis show that direct providers were more likely than non-providers to agree that each of the four services showing significance are provided for minors without parental consent. No significant differences were found for services relating to acne, menstruation, abortion, obesity, sterilization, and breast examinations.

Direct Provision and Minors' Knowledge

As noted on Table XXXI, significant differences regarding nurses' opinions of minors' knowledge were indicated on three health services of special interest to minors in relation to the nurses' direct provision of services. Differences at $p < .05$ were found for contraceptive services, treatment for venereal disease, and pregnancy testing. Nurses who were providers were more likely to agree that they believed minors knew of the availability of the services. For the other seven services no significant differences were found.

Summary of Nurses' Direct Provision of Services By Their Opinions Concerning Health Services

No significant differences were found when beliefs of nurses regarding the advisability of health services were tested by their participation in direct provision of services to minors. Direct providers were more likely to agree that services relating to venereal

TABLE XXX

SUMMARY OF CHI SQUARE TESTS OF NURSES' DIRECT PROVISION OF SERVICES BY SERVICES THEY BELIEVE ARE AVAILABLE

Service	N	Chi Square Value	Degrees of Freedom	Probability
Treatment for pustular acne	164	3.01	4	0.5565
Treatment for menstrual problems	166	4.30	4	0.3666
Contraceptive services	165	17.97	4	0.0012
Treatment for venereal disease	167	12.49	4	0.0141
Abortion services	166	3.23	4	0.5201
Treatment for obesity	164	4.30	4	0.3665
Sterilization services	166	3.75	4	0.4408
Pelvic examinations	165	10.66	4	0.0306
Pregnancy testing	167	24.46	4	0.0001
Breast examinations	167	7.66	4	0.1047

TABLE XXXI

SUMMARY OF CHI SQUARE TESTS OF NURSES' DIRECT PROVISION OF SERVICES BY SERVICES THEY BELIEVE MINORS KNOW ARE AVAILABLE

Service	N	Chi Square Value	Degrees of Freedom	Probability
Treatment for pustular acne	164	2.41	4	0.6615
Treatment for menstrual problems	166	4.23	4	0.3756
Contraceptive services	168	13.14	4	0.0106
Treatment for venereal disease	167	11.74	4	0.0194
Abortion services	165	5.45	4	0.2445
Treatment for obesity	166	9.22	4	0.0559
Sterilization services	166	4.74	4	0.3150
Pelvic examinations	168	8.17	4	0.0854
Pregnancy testing	167	11.00	4	0.0266
Breast examinations	165	7.24	4	0.1236

disease, pelvic examinations, pregnancy testing, and contraception were provided without parental consent and they were more likely to agree that minors knew that services related to contraception, venereal disease, and pregnancy testing were available to them.

Relationship Between Field of Employment and Opinions Concerning Health Services

Hospitals as Place of Employment

One of the demographic variables tested for significance in regard to nurses' opinions related to health services for minors was their field of employment. Eight fields of employment that were identified and used by the Oklahoma State Health Department were included. Nurses retired or employed in locations other than the listed categories were grouped together.

Responses from nurses employed in hospitals were not significantly different from other nurses regarding their opinions concerning health services for minors in Oklahoma without parental consent (Tables XXXII, XXXIII, and XXXIV). As shown in Table XXXII, no significant differences were observed for hospital nurses and other nurses regarding services they believed should be available.

Chi square tests of nurses working in hospitals by other nurses regarding health services they believed were available to minors in Oklahoma without parental consent are presented in Table XXXIII. No significant differences were found when nurses' opinions of services available were tested by hospital as a place of employment. Results of tests on nurses employed in hospitals by other nurses regarding

TABLE XXXII

SUMMARY OF CHI SQUARE TESTS OF NURSES EMPLOYED IN HOSPITALS BY OTHER NURSES REGARDING SERVICES THEY BELIEVE SHOULD BE AVAILABLE

Service	N	Chi Square Value	Degrees of Freedom	Probability
Treatment for pustular acne	191	0.60	2	0.7412
Treatment for menstrual problems	190	1.46	2	0.4808
Contraceptive services	189	3.97	2	0.1376
Treatment for venereal disease	188	0.68	2	0.7137
Abortion services	191	5.82	2	0.0545
Treatment for obesity	192	0.04	2	0.9776
Sterilization services	191	0.21	2	0.9013
Pelvic examinations	190	0.28	2	0.8680
Pregnancy testing	189	1.61	2	0.4461
Breast examinations	188	5.05	2	0.0802

TABLE XXXIII

SUMMARY OF CHI SQUARE TESTS OF NURSES EMPLOYED IN HOSPITALS BY OTHER NURSES REGARDING SERVICES THEY BELIEVE ARE AVAILABLE

Service	N	Chi Square Value	Degrees of Freedom	Probability
Treatment for pustular acne	173	0.86	2	0.6493
Treatment for menstrual problems	175	0.21	2	0.9017
Contraceptive services	175	2.41	2	0.2991
Treatment for venereal disease	177	2.46	2	0.2930
Abortion services	176	1.68	2	0.4312
Treatment for obesity	173	0.60	2	0.7409
Sterilization services	175	2.38	2	0.3035
Pelvic examinations	173	0.38	2	0.8273
Pregnancy testing	176	0.53	2	0.7689
Breast examinations	176	4.36	2	0.1129

services they believed minors knew were available are shown in Table XXXIV. Again, chi square analysis indicated there were no significant differences related to nurses' employment in a hospital.

Nursing Home as Place of Employment

Nurses employed in nursing homes and other nurses were tested for differences regarding advisability, availability, and minors' knowledge of availability of health services (Tables XXXV, XXXVI, and XXXVII). No significant differences were found when these major variables were tested by nursing home as place of employment.

Schools of Nursing as Place of Employment

In the chi square tests of nurses employed in schools of nursing and other nurses regarding their opinions concerning advisability of 10 selected health services for minors without parental consent, no differences were detected (Table XXXVIII). Differences were found, however, for one service when the availability of services was tested by school of nursing as a place of employment (Table XXXIX). Responses to the availability of breast examinations were significant ($p < .05$). Observation of contingency table cells shows that nurses employed in schools of nursing are more likely to disagree that breast examinations were available to minors.

Nurses' responses to minors' knowledge of the availability of health services are presented in Table XL. School of nursing as a place of employment was not a significant source of difference for minors' knowledge of any of the 10 health services.

TABLE XXXIV

SUMMARY OF CHI SQUARE TESTS OF NURSES EMPLOYED IN HOSPITALS BY OTHER NURSES REGARDING SERVICES THEY BELIEVE MINORS KNOW ARE AVAILABLE

Service	N	Chi Square Value	Degrees of Freedom	Probability
Treatment for pustular acne	173	5.11	2	0.0778
Treatment for menstrual problems	176	5.65	2	0.0592
Contraceptive services	178	2.72	2	0.2560
Treatment for venereal disease	177	1.39	2	0.4980
Abortion services	175	0.28	2	0.8695
Treatment for obesity	175	0.02	2	0.9922
Sterilization services	175	1.77	2	0.4119
Pelvic examinations	176	0.76	2	0.6845
Pregnancy testing	176	0.63	2	0.7307
Breast examinations	174	1.75	2	0.4162

TABLE XXXV

SUMMARY OF CHI SQUARE TESTS OF NURSES EMPLOYED IN NURSING HOMES BY OTHER NURSES REGARDING SERVICES THEY BELIEVE SHOULD BE AVAILABLE

Service	N	Chi Square Value	Degrees of Freedom	Probability
Treatment for pustular acne	191	1.72	2	0.4240
Treatment for menstrual problems	190	1.22	2	0.5444
Contraceptive services	189	2.99	2	0.2243
Treatment for venereal disease	188	3.17	2	0.2053
Abortion services	191	3.27	2	0.1947
Treatment for obesity	192	0.67	2	0.7149
Sterilization services	191	3.71	2	0.1564
Pelvic examinations	190	9.87	2	0.0072[1]
Pregnancy testing	189	5.00	2	0.0820
Breast examinations	188	3.57	2	0.1678

[1]Over 20 percent of the cells had expected counts of less than five. Table was so sparse that chi square may not be a valid test.

TABLE XXXVI

SUMMARY OF CHI SQUARE TESTS OF NURSES EMPLOYED IN NURSING HOMES BY OTHER NURSES REGARDING SERVICES THEY BELIEVE ARE AVAILABLE

Service	N	Chi Square Value	Degrees of Freedom	Probability
Treatment for pustular acne	173	0.26	2	0.8759
Treatment for menstrual problems	175	1.25	2	0.5363
Contraceptive services	175	0.41	2	0.8141
Treatment for venereal disease	177	4.44	2	0.1084
Abortion services	176	3.80	2	0.1493
Treatment for obesity	173	1.31	2	0.5184
Sterilization services	175	0.58	2	0.7482
Pelvic examinations	173	0.20	2	0.9025
Pregnancy testing	176	2.83	2	0.2429
Breast examinations	176	1.29	2	0.5256

TABLE XXXVII

SUMMARY OF CHI SQUARE TESTS OF NURSES EMPLOYED IN NURSING HOMES BY OTHER NURSES REGARDING SERVICES THEY BELIEVE MINORS KNOW ARE AVAILABLE

Service	N	Chi Square Value	Degrees of Freedom	Probability
Treatment for pustular acne	173	1.32	2	0.5180
Treatment for menstrual problems	176	0.59	2	0.7456
Contraceptive services	178	3.10	2	0.2119
Treatment for venereal disease	177	4.57	2	0.1017
Abortion services	175	10.23	2	0.0060[1]
Treatment for obesity	175	1.69	2	0.4304
Sterilization services	175	2.70	2	0.2595
Pelvic examinations	176	4.38	2	0.1120
Pregnancy testing	176	4.20	2	0.1225
Breast examinations	174	3.64	2	0.1624

[1]Over 20 percent of the cells had expected counts of less than five. Table was so sparse that chi square may not be a valid test.

TABLE XXXVIII

SUMMARY OF CHI SQUARE TESTS OF NURSES EMPLOYED IN SCHOOLS OF NURSING BY OTHER NURSES REGARDING SERVICES THEY BELIEVE SHOULD BE AVAILABLE

Service	N	Chi Square Value	Degrees of Freedom	Probability
Treatment for pustular acne	191	1.11	2	0.5750
Treatment for menstrual problems	190	0.72	2	0.6979
Contraceptive services	189	0.59	2	0.7453
Treatment for venereal disease	188	1.78	2	0.4108
Abortion services	191	1.98	2	0.3714
Treatment for obesity	192	4.06	2	0.1317
Sterilization services	191	1.75	2	0.4169
Pelvic examinations	190	1.38	2	0.5029
Pregnancy testing	189	4.28	2	0.1178
Breast examinations	188	2.80	2	0.2462

TABLE XXXIX

SUMMARY OF CHI SQUARE TESTS OF NURSES EMPLOYED IN SCHOOLS OF NURSING BY OTHER NURSES REGARDING SERVICES THEY BELIEVE ARE AVAILABLE

Service	N	Chi Square Value	Degrees of Freedom	Probability
Treatment for pustular acne	173	5.13	2	0.0768
Treatment for menstrual problems	175	2.89	2	0.2359
Contraceptive services	175	0.73	2	0.6936
Treatment for venereal disease	177	0.30	2	0.8622
Abortion services	176	2.75	2	0.2526
Treatment for obesity	173	1.80	2	0.4060
Sterilization services	175	0.84	2	0.6564
Pelvic examinations	173	5.54	2	0.0627
Pregnancy testing	176	4.87	2	0.0875
Breast examinations	176	7.16	2	0.0279

TABLE XL

SUMMARY OF CHI SQUARE TESTS OF NURSES EMPLOYED IN SCHOOLS OF NURSING BY OTHER NURSES REGARDING SERVICES THEY BELIEVE MINORS KNOW ARE AVAILABLE

Service	N	Chi Square Value	Degrees of Freedom	Probability
Treatment for pustular acne	173	2.05	2	0.3594
Treatment for menstrual problems	176	2.92	2	0.2324
Contraceptive services	178	1.90	2	0.3875
Treatment for venereal disease	177	4.20	2	0.1222
Abortion services	175	0.58	2	0.7499
Treatment for obesity	175	2.50	2	0.2865
Sterilization services	175	0.79	2	0.6733
Pelvic examinations	176	6.08	2	0.0479[1]
Pregnancy testing	176	2.14	2	0.3431
Breast examinations	174	6.97	2	0.0306[1]

[1]Over 20 percent of the cells had expected counts of less than five. Table was so sparse that chi square may not be a valid test.

Private Duty as Place of Employment

There were too few nurses employed in private duty (n = 4) to enable the researcher to conduct meaningful tests. The computer program used by the researcher (Helwig, 1978) automatically issued a warning when 20 percent of the cells of a contingency table had expected values less than five.

Public Health as Place of Employment

Comparisons of responses of nurses employed in public health by other nurses regarding advisability, availability, and minors' knowledge are recorded in Tables XLI, XLII, and XLIII. When nurses' opinions of the advisability of health services were analyzed, public health as a place of employment was significant ($p < .05$) for pustular acne (Table XLI). The contingency table cell making the largest contribution to the total chi square value was the cell representing public health nurses who disagreed that it should be available. The proportion of public health nurses who disagreed with the advisability of providing treatment for pustular acne for minors without parental consent was greater than the proportion of other nurses who disagreed.

There were no significant differences noted when testing responses of public health nurses by other nurses regarding health services they believed were available (Table XLII), however, treatment for obesity was significant ($p < .05$) when the same nurses responded regarding services minors knew were available (Table XLIII). A greater proportion of public health nurses than other nurses believed that minors knew obesity treatment was available to them without parental consent.

TABLE XLI

SUMMARY OF CHI SQUARE TESTS OF NURSES EMPLOYED IN PUBLIC HEALTH BY OTHER NURSES REGARDING SERVICES THEY BELIEVE SHOULD BE AVAILABLE

Service	N	Chi Square Value	Degrees of Freedom	Probability
Treatment for pustular acne	191	7.52	2	0.0233
Treatment for menstrual problems	190	0.92	2	0.6304
Contraceptive services	189	4.74	2	0.0936
Treatment for venereal disease	188	1.78	2	0.4108
Abortion services	191	0.21	2	0.9014
Treatment for obesity	192	3.44	2	0.1793
Sterilization services	191	4.91	2	0.0859
Pelvic examinations	190	1.52	2	0.4670
Pregnancy testing	189	2.01	2	0.3662
Breast examinations	188	4.21	2	0.1219

TABLE XLII

SUMMARY OF CHI SQUARE TESTS OF NURSES EMPLOYED IN PUBLIC HEALTH BY OTHER NURSES REGARDING SERVICES THEY BELIEVE ARE AVAILABLE

Service	N	Chi Square Value	Degrees of Freedom	Probability
Treatment for pustular acne	173	3.84	2	0.1468
Treatment for menstrual problems	175	0.15	2	0.9282
Contraceptive services	175	0.87	2	0.6479
Treatment for venereal disease	177	4.11	2	0.1281
Abortion services	176	0.29	2	0.8646
Treatment for obesity	173	0.57	2	0.7534
Sterilization services	175	0.65	2	0.7235
Pelvic examinations	173	2.61	2	0.2716
Pregnancy testing	176	0.44	2	0.8007
Breast examinations	176	3.28	2	0.1943

TABLE XLIII

SUMMARY OF CHI SQUARE TESTS OF NURSES EMPLOYED IN PUBLIC HEALTH BY OTHER NURSES REGARDING SERVICES THEY BELIEVE MINORS KNOW ARE AVAILABLE

Service	N	Chi Square Value	Degrees of Freedom	Probability
Treatment for pustular acne	173	2.17	2	0.3377
Treatment for menstrual problems	176	1.53	2	0.4649
Contraceptive services	178	1.74	2	0.4200
Treatment for venereal disease	177	2.86	2	0.2391
Abortion services	175	4.86	2	0.0881
Treatment for obesity	175	6.18	2	0.0454
Sterilization services	175	0.40	2	0.8177
Pelvic examinations	176	4.39	2	0.1115
Pregnancy testing	176	2.20	2	0.3323
Breast examinations	174	3.26	2	0.1956

Schools as Place of Employment

There were too few nurses employed in schools (n = 8) to enable the researcher to conduct meaningful tests. The computer program used by the researcher (Helwig, 1978) automatically issued a warning when 20 percent of the cells of a contingency table had expected values less than five.

Industry as Place of Employment

There were four industrial nurses who participated in the study. This number was too few to enable the researcher to conduct valid chi square tests.

Physician's Office as Place of Employment

Nurses who are employed in physicians' offices were tested by other nurses concerning their opinions regarding the advisability, availability, and minors' knowledge of services available for minors in Oklahoma without parental consent. Table XLIV presents a summary of results concerning nurses' opinions of the advisability of services. No significant differences were found. Results for chi square tests of office nurses by other nurses regarding health services they believed were available are shown in Table XLV. Again, no significant differences were found.

Results in Table XLVI represent tests of office nurses by other nurses regarding minors' knowledge of services available without parental consent. Significance ($p < .05$) was found for pelvic examinations. Cell observation reveals that a greater proportion of

TABLE XLIV

SUMMARY OF CHI SQUARE TESTS OF NURSES EMPLOYED IN PHYSICIANS' OFFICES BY OTHER NURSES REGARDING SERVICES THEY BELIEVE SHOULD BE AVAILABLE

Service	N	Chi Square Value	Degrees of Freedom	Probability
Treatment for pustular acne	191	3.15	2	0.2072
Treatment for menstrual problems	190	1.38	2	0.5023
Contraceptive services	189	0.94	2	0.6251
Treatment for venereal disease	188	0.30	2	0.8585
Abortion services	191	0.28	2	0.8710
Treatment for obesity	192	2.77	2	0.2504
Sterilization services	191	1.26	2	0.5324
Pelvic examinations	190	1.38	2	0.5029
Pregnancy testing	189	0.19	2	0.9077
Breast examinations	188	2.92	2	0.2321

TABLE XLV

SUMMARY OF CHI SQUARE TESTS OF NURSES EMPLOYED IN PHYSICIANS' OFFICES BY OTHER NURSES REGARDING SERVICES THEY BELIEVE ARE AVAILABLE

Service	N	Chi Square Value	Degrees of Freedom	Probability
Treatment for pustular acne	173	1.36	2	0.5076
Treatment for menstrual problems	175	3.64	2	0.1616
Contraceptive services	175	1.98	2	0.3708
Treatment for venereal disease	177	0.59	2	0.7450
Abortion services	176	0.16	2	0.9252
Treatment for obesity	173	2.19	2	0.3339
Sterilization services	175	1.79	2	0.4087
Pelvic examinations	173	3.91	2	0.1414
Pregnancy testing	176	3.67	2	0.1595
Breast examinations	176	1.05	2	0.5908

TABLE XLVI

SUMMARY OF CHI SQUARE TESTS OF NURSES EMPLOYED IN PHYSICIANS' OFFICES BY OTHER NURSES REGARDING SERVICES THEY BELIEVE MINORS KNOW ARE AVAILABLE

Service	N	Chi Square Value	Degrees of Freedom	Probability
Treatment for pustular acne	173	0.77	2	0.6799
Treatment for menstrual problems	176	2.08	2	0.3539
Contraceptive services	178	4.73	2	0.0941
Treatment for venereal disease	177	1.33	2	0.5139
Abortion services	175	0.94	2	0.6260
Treatment for obesity	175	4.55	2	0.1027
Sterilization services	175	4.25	2	0.1192
Pelvic examinations	176	6.09	2	0.0477
Pregnancy testing	176	4.86	2	0.0882
Breast examinations	174	1.21	2	0.5469

office nurses than other nurses believed minors knew of pelvic examinations available to them without parental consent.

Other Places of Employment

Nurses who were not employed in the categories or specific locations listed on the questionnaire were grouped together for analysis. Included in this group of nurses were those who considered themselves unemployed or retired. The responses of these nurses were compared with other nurses regarding their opinions of health service advisability, availability, and minors' knowledge of availability in Oklahoma without parental consent (Tables XLVII, XLVIII, and XLIX).

When responses of the nurses employed in this category were compared with other registered nurses regarding health services they believed should be available, responses for three services were found significant (Table XLVII).

Contraceptive services, treatment for venereal disease, and breast examinations were found significant at the $p < .05$ level. In each of these cases, a greater proportion of the nurses who were employed in areas other than those specifically listed on the questionnaire disagreed that health services should be available to minors without parental consent.

Summary of Nurses' Fields of Employment

In tests of differences of nurses' opinions regarding advisability of health services without parental consent by their fields of employment, nurses who were employed in public health were significantly different from other nurses in their opinions concerning treatment for

TABLE XLVII

SUMMARY OF CHI SQUARE TESTS OF NURSES RETIRED FROM OR EMPLOYED IN FIELDS NOT LISTED IN THE OKLAHOMA STATE DEPARTMENT OF HEALTH CATEGORIES BY OTHER NURSES REGARDING SERVICES THEY BELIEVE SHOULD BE AVAILABLE

Service	N	Chi Square Value	Degrees of Freedom	Probability
Treatment for pustular acne	191	1.93	2	0.3811
Treatment for menstrual problems	190	1.28	2	0.5266
Contraceptive services	189	8.45	2	0.0146
Treatment for venereal disease	188	6.90	2	0.0317
Abortion services	191	0.58	2	0.7494
Treatment for obesity	192	0.50	2	0.7805
Sterilization services	191	1.44	2	0.4866
Pelvic examinations	190	4.54	2	0.1033
Pregnancy testing	189	3.58	2	0.1672
Breast examinations	188	6.30	2	0.0430

TABLE XLVIII

SUMMARY OF CHI SQUARE TESTS OF NURSES RETIRED FROM OR EMPLOYED IN FIELDS NOT LISTED IN THE OKLAHOMA STATE DEPARTMENT OF HEALTH CATEGORIES BY OTHER NURSES REGARDING SERVICES THEY BELIEVE ARE AVAILABLE

Service	N	Chi Square Value	Degrees of Freedom	Probability
Treatment for pustular acne	173	1.28	2	0.5260
Treatment for menstrual problems	175	0.27	2	0.8731
Contraceptive services	175	0.26	2	0.8799
Treatment for venereal disease	177	1.94	2	0.3787
Abortion services	176	0.84	2	0.6583
Treatment for obesity	173	0.01	2	0.9963
Sterilization services	175	0.23	2	0.8920
Pelvic examinations	173	0.58	2	0.7469
Pregnancy testing	176	0.42	2	0.8105
Breast examinations	176	0.73	2	0.6948

TABLE XLIX

SUMMARY OF CHI SQUARE TESTS OF NURSES RETIRED FROM OR EMPLOYED IN FIELDS NOT LISTED IN THE OKLAHOMA STATE DEPARTMENT OF HEALTH CATEGORIES BY OTHER NURSES REGARDING SERVICES THEY BELIEVE MINORS KNOW ARE AVAILABLE

Service	N	Chi Square Value	Degrees of Freedom	Probability
Treatment for pustular acne	173	3.34	2	0.1884
Treatment for menstrual problems	176	4.18	2	0.1239
Contraceptive services	178	3.99	2	0.1358
Treatment for venereal disease	177	1.25	2	0.5348
Abortion services	175	0.86	2	0.6488
Treatment for obesity	175	1.50	2	0.4714
Sterilization services	175	1.03	2	0.5964
Pelvic examinations	176	3.17	2	0.2053
Pregnancy testing	176	0.33	2	0.8470
Breast examinations	174	1.97	2	0.3728

pustular acne. Nurses retired from or employed in field not specifically listed on the questionnaire were different from other nurses in their opinions of the advisability of contraceptive services, treatment for venereal disease, and breast examinations. Significance was found for nurses employed in schools of nursing regarding the availability of breast examinations. Significance was found for two services when nurses' opinions regarding minors' knowledge were tested by field of employment. Public health nurses were different from other nurses regarding treatment for obesity and nurses employed in physicians' offices were different from other nurses regarding pelvic examinations.

Summary of the Results of the Study

Demographic data obtained from the nurses who participated in the study showed that over half of the nurses who participated had worked in health services for 15 years or less and almost half of them had worked in their present communities for five years or less. A high proportion of the nurses responding worked in metropolitan areas, a majority were employed in hospitals, and slightly fewer than 50 percent provided direct services to minors.

Of the 10 health services of special interest to minors that were tested, abortion services and sterilization services were the only two for which the number of nurses who did not believe they should be available outnumbered those who did. Sixty percent or more agreed that each of the other eight services should be available to minors without parental consent and more nurses agreed than disagreed that all services except abortion and sterilization were available to minors.

The number of nurses who believed minors knew of services was greater than those who did not believe minors knew of them for treatment for venereal disease, pregnancy testing, and breast examinations.

More than two-thirds of the respondents recommended changes in the Oklahoma law regarding health services for minors. Those preferring greater access to health services for minors outnumbered those who did not. Nurses who believed the present law increased first and repeat pregnancies were more numerous than those who believed it decreased them. Approximately two-thirds of the nurses believed there had been an increase in lawful abortions. Three-fifths of the nurses perceived an increase in early contacts with health professionals by pregnant minors.

Using chi square analysis, a significant relationship was found when nurses' opinions regarding advisability were tested by their opinions of availability for all services. When nurses' opinions regarding the advisability were tested by their opinions of minors' knowledge, significance was found for each of the services except contraception and venereal disease. When nurses opinions regarding availability of health services for minors were tested by minors' knowledge, significance was found for all of the services.

Being a direct provider of health services for minors was related to nurses' opinions regarding the availability of contraceptive services, treatment for venereal disease, pelvic examinations, and pregnancy testing, and minors' knowledge of contraceptive services, treatment for venereal disease, and pregnancy testing. Significance was found for advisability of pustular acne treatment when public health nurses were tested by other nurses and for availability of

breast examinations when nurses employed in schools of nursing were compared with other nurses. When public health nurses were tested by other nurses regarding their opinions of minors' knowledge, significance was found for treatment for obesity and significance was found for pelvic examinations when nurses employed in physicians' offices were tested by other nurses regarding minors' knowledge. There were too few nurses employed in private duty, schools, and industry to conduct meaningful tests for these areas.

CHAPTER V

SUMMARY AND RECOMMENDATIONS

Summary

The research study is summarized in Chapter V. This section provides information about the problem, objectives, hypotheses, sample, instrument design, data collection, statistical treatment, results, and conclusions.

Statement of the Problem

The rights of citizens to use laws have not always been the same, especially if the citizens were minors. Because of their age, minors in Oklahoma who sought health care have been restricted by conditions placed upon them by Oklahoma's law addressing health services for minors. Oklahoma state law 63 O.S., Sections 2601-2602 listed specific circumstances under which minors in Oklahoma might receive health care without parental consent. The conditions which qualified minors for the privilege of such services were frequently viewed negatively by society, however, minors who wanted the services without confronting their parents had to meet these social eligibility requirements or do without the health care.

Timing of the health care was often critical, especially when the services related to health care pertaining to sexual matters. Contaception needs, pregnancy testing and care, and abortion services were

all services for which the timing might be critical. If minors hesitated to inform parents of sex-related health problems, under Oklahoma law they were at risk of not being able to obtain the health services when care was needed.

Of special interest in this study were health services related to adolescent pregnancy. Oklahoma's high national rank in teenage pregnancy made a study of the law governing health care related to adolescent pregnancy especially appropriate.

The focus of this study was to determine opinions of registered nurses regarding their beliefs about the advisability, availability, and minors' knowledge of the availability of health services for minors in Oklahoma without parental consent. Personal information about the respondents was obtained to ascertain relationships between demographic factors and their opinions. The nurses' beliefs regarding impact and adequacy of the law pertaining to health services for minors were also evaluated.

Objectives

The objectives of this study were:

1. Obtain the opinions of registered nurses in Oklahoma regarding the provision of health services for minors without parental consent.

2. Determine if any relationships exist between nurses' opinions of the advisability and availability of health services for minors without parental consent.

3. Determine if any relationships exist between nurses' opinions of the advisability and their beliefs regarding minors' knowledge of availability of health services for minors without parental consent.

4. Determine if any relationships exist between nurses' opinions of the availability and their beliefs regarding minors' knowledge of availability of health services for minors without parental consent.

5. Obtain the perceptions of registered nurses regarding the impacts of Oklahoma law relating to health services for minors without parental consent.

6. Determine whether nurses' opinions of the advisability of health services for minors without parental consent varies with the classification of the services as related or unrelated to sexual behavior.

7. Determine whether nurses' opinions of the availability of health services for minors without parental consent varies with the classification of the services as related or unrelated to sexual behavior.

8. Determine if any relationships exist among the major variables of study (advisability, availability, and minors' knowledge) and nurses' demographic variables.

9. Determine if place of employment is associated with nurses' direct delivery of health services for minors.

Sample Selection

A sample of 446 nurses was randomly drawn by computer from over 9,000 names of registered nurses who held certificates permitting practice in Oklahoma. The names were obtained from the Oklahoma Board of Nurse Registration and Nursing Education. Through random sampling each individual in the population had the same non-zero chance of being selected.

Instrument Design

The Health Services for Minors Questionnaire developed by the researcher contained four sections. The first part obtained the opinions of registered nurses on the advisability, availability, and minors' knowledge of the availability of ten services for minors in Oklahoma without parental consent. The ten health services of special interest to minors were determined from the literature and were randomly listed on the questionnaire. Five of the health services were associated with sexual behavior and five of the services were considered common to the age and were not associated with sexual conduct. The five services that dealt with sexual behavior were contraception services, treatment for venereal disease, abortion services, sterilization services, and pregnancy testing. The five health needs not associated with sexual conduct were treatment for pustular acne, treatment for menstrual problems, treatment for obesity, pelvic examinations, and breast examinations.

Part II of the instrument measured the nurses' opinions regarding impacts of Oklahoma law addressing health services for minors. Nurses responded on a Likert-type scale to six randomly listed impacts that were frequently noted in the literature as being concerns for pregnant minors. The impacts concerned early health professional contact, repeat pregnancies, unlawful abortions, lawful abortions, first pregnancies, and health risks.

There was opportunity for respondents to provide written comments in Part III. They were given a chance to reply to questions addressing the advisability of a change in the Oklahoma health services for minors

law. Nurses were also asked to suggest changes in the law, and give reasons why the changes were recommended.

Demographic data were obtained from Part IV of the questionnaire. Nurses were requested to provide information about the number of years they had worked in health services, the number of years they had worked in their present communities, the state planning districts in which they worked, their direct involvement in provision of health services for minors, and their current fields of employment.

Stages of instrument development first included reviews by persons knowledgeable of medical services, questionnaire development, and adolescent health needs. The second stage of development involved the administration of the instrument to a task force of qualified individuals interested in adolescent problems. The third and final stage of preparation was refinement based on reviews by a physician, statistician, and several home economists including the dissertation adviser. A copy of the Health Services for Minors Questionnaire is included in Appendix A.

Data Collection

The questionnaires were mailed by first class mail on April 24, 1981. The entire packet that was mailed included the three page questionnaire with an attached state planning district map, cover letter, stamped and addressed return envelope, and stamped and addressed participation card. Return was requested by May 8. Sample names for which participation cards had not been received were mailed second questionnaires on May 30 and replies were requested by June 15. There were 199 nurses who responded. Two others were known to be ineligible

because of death and eight more were known to be ineligible because they responded that they had moved out-of-state. Eight questionnaires were returned by the postal service because of address change. Response rate for nurses believed to be eligible was 46.5 percent. It is not known how many of the non-respondents were in fact not eligible. (See Appendix B for correspondence.)

Statistical Procedures

Collected data were recorded on Fortran coding forms, then key punched at the Oklahoma State University Computer Center. Statistical Analysis System (Helwig, 1978) was the statistical program used for all analyses. Frequencies and percentages were used for portions of the data and chi square analysis was used for tests of differences. A summary of objectives, null hypotheses, and analytical procedures is shown in Table L.

Results and Conclusions

The results of the study, consistent with the stated objectives and hypotheses of the study are reported as follows:

1. A majority of respondents believed treatment for venereal disease, pelvic examinations, pregnancy testing, and breast examinations were available for minors in Oklahoma without parental consent. More nurses agreed than disagreed that treatment for pustular acne, treatment for menstrual problems, contraceptive services, and treatment for obesity were available. A majority of nurses believed abortion services and sterilization services were not available to minors in Oklahoma without parental consent.

TABLE L

SUMMARY OF RESEARCH OBJECTIVES, NULL HYPOTHESES AND ANALYTICAL PROCEDURES

Null Hypotheses	Research Objectives[1]	Analytical Procedures
1. There are no differences among nurses' opinions of the advisability of health services for minors without parental consent associated with nurses' opinions of the availability of health services for minors without parental consent.	No. 2	Chi Square
2. There are no differences among nurses' opinions of the advisability of health services for minors without parental consent associated with nurses' opinions regarding minors' knowledge of health services available without parental consent.	No. 3	Chi Square
3. There are no differences among nurses' opinions of the availability of health services for minors without parental consent associated with nurses' opinions regarding minors' knowledge of health services for minors available without parental consent.	No. 4	Chi Square
4. There are no differences among nurses' opinions of the advisability of health services for minors without parental consent associated with nurses' demographic variables.	No. 8	Chi Square
5. There are no differences among nurses' opinions of the availability of health services for minors without parental consent associated with nurses' demographic variables.	No. 8	Chi Square

TABLE L (Continued)

Null Hypotheses	Research Objectives	Analytical Procedures
6. There are no differences among nurses' opinions of minors' knowledge of the availability of health services for minors without parental consent associated with nurses' demographic variables.	No. 8	Chi Square
7. There are no differences in nurses' direct provision of health services for minors without parental consent associated with current field of employment.	No. 9	Chi Square

2. A majority of nurses believed that treatment for pustular acne, treatment for menstrual problems, contraceptive services, treatment for venereal disease, treatment for obesity, pelvic examinations, pregnancy testing, and breast examinations should be available for minors in Oklahoma without parental consent or knowledge. A majority of the nurses also felt abortion services and sterilization services should not be available without parental consent.

3. More than two-thirds of the respondents believed that the Oklahoma laws regarding health services for minors should be changed. Fewer than 20 percent of the respondents wanted the law to be more conservative.

4. There was a relationship between the opinions of nurses regarding services that should be available and those that were available.

5. The opinions of nurses regarding services that should be available were different from those they believed minors knew were available for all services except contraception services and treatment for venereal disease.

6. There was significance between the opinions of nurses regarding services they believed were available and those they believed minors knew were available.

7. Nurses' direct provision of health services to minors was related to their opinions regarding the availability of contraceptive services, treatment for venereal disease, pelvic examinations, and pregnancy testing.

8. Opinions of nurses employed in schools of nursing were significantly different from other nurses regarding the availability of

breast examinations.

9. Opinions of nurses employed in public health were significantly different from other nurses regarding the advisability of treatment for pustular acne.

10. Opinions of nurses retired from or employed in categories not specified in the questionnaire were significantly different from other nurses regarding the advisability of contraceptive services, treatment for venereal disease, and breast examinations.

11. Nurses' direct provision of health services to minors was related to their opinions regarding minors' knowledge of the availability of contraceptive services, treatment for venereal disease, and pregnancy testing.

12. Opinions of nurses employed in public health were significantly different from other nurses regarding minors' knowledge of the availability of treatment for obesity.

13. Opinions of nurses employed in physicians' offices were significantly different from other nurses regarding minors' knowledge of the availability of pelvic examinations.

14. The opinions of nurses regarding health services for minors in Oklahoma without parental consent were different for two of five services related to sexual behavior. Abortion services and sterilization services were not considered desirable by the respondents.

Demographic variables and the 10 health services were most easily presented and read in tabular form. A matrix of rejection decisions of sub-hypotheses relating to tests of advisability by demographic variables is presented in Table LI. Table LII presents a rejection matrix relating to tests of availability by demographic variables and Table

TABLE LI

MATRIX OF NULL HYPOTHESES DECISIONS REGARDING ADVISABILITY OF HEALTH SERVICES BY DEMOGRAPHIC VARIABLES

Null Hypothesis: There are no differences among nurses' opinions of the advisability of health services for minors without parental consent associated with nurses' demographic variables.[1]

Health Services / Demographic Variables	Number of years in health services	Number of years in present community	State planning district	Direct provision of health services	Field of employment Hospital	Nursing home	School of nursing	Private duty	Public health	School nurse	Industry	Physician's office	Other
1. Treatment for Pustular Acne									•				
2. Treatment for menstrual problems													
3. Contraceptive services													•
4. Treatment for venereal disease													•
5. Abortion services													
6. Treatment for obesity													
7. Sterilization services													
8. Pelvic examinations													
9. Pregnancy testing													
10. Breast examinations													•

[1]Null hypotheses that were rejected are indicated by a dot.

TABLE LII

MATRIX OF NULL HYPOTHESES DECISIONS REGARDING AVAILABILITY OF HEALTH SERVICES BY DEMOGRAPHIC VARIABLES

Null Hypothesis: There are no differences among nurses' opinions of the availability of health services for minors without parental consent associated with nurses' demographic variables.[1]

Health Services / Demographic Variables	Number of years in health services	Number of years in present community	State planning district	Direct provision of health services	Field of employment: Hospital	Nursing home	School of nursing	Private duty	Public health	School nurse	Industry	Physician's office	Other
1. Treatment for pustular acne													
2. Treatment for menstrual problems													
3. Contraceptive services				•									
4. Treatment for venereal disease				•									
5. Abortion services													
6. Treatment for obesity													
7. Sterilization services													
8. Pelvic examinations				•									
9. Pregnancy testing				•									
10. Breast examinations							•						

[1]Null hypotheses that were rejected are indicated by a dot.

LIII presents rejection decisions regarding minors' knowledge of availability by demographic variables.

Recommendations and Observations

Recommendations and observations presented in this section are in two parts: (1) those relating to the design of the questionnaire and (2) those relating to the substantive content of the study.

Observations on Questionnaire Design

For the benefit of other researchers who may be interested in pursuing further study, the following observations about instrument design are made:

1. Chi square analysis would have been a more reliable test if the respondents had been grouped into fewer cells. Omitting the undecided column and requiring a forced choice would provide more usable data.

2. The number of nurses who indicated that they were retired justifies adding a retirement category to the fields of employment.

3. In view of several respondents indicating that they did not know Oklahoma law regarding health services for minors, a change in the method of presentation of the law in the questionnaire is advisable. Altering the appearance of that portion of the questionnaire by addition of borders, type size or style variation, or color would separate law information from questionnaire instructions and possibly encourage respondents to carefully read the law.

TABLE LIII

MATRIX OF NULL HYPOTHESES DECISIONS REGARDING MINORS' KNOWLEDGE OF AVAILABILITY OF HEALTH SERVICES BY DEMOGRAPHIC VARIABLES

Null Hypothesis: There are no differences among nurses' opinions of minors' knowledge of the availability of health services for minors without parental consent associated with nurses' demographic variables.[1]

Health Services / Demographic Variables	Number of years in health services	Number of years in present community	State planning district	Direct provision of health services	Field of employment: Hospital	Nursing home	School of nursing	Private duty	Public health	School nurse	Industry	Physician's office	Other
1. Treatment for pustular acne													
2. Treatment for menstrual problems													
3. Contraceptive services				•									
4. Treatment for venereal disease				•									
5. Abortion services													
6. Treatment for obesity									•				
7. Sterilization services													
8. Pelvic examinations												•	
9. Pregnancy testing				•									
10. Breast examinations													

[1]Null hypotheses that were rejected are indicated by a dot.

4. Addition of an example would provide clarity for Part II of the questionnaire on impacts of the law. It is possible that respondents who did not read or understand the directions would have benefitted from a step-by-step explanation.

Recommendations on Substantive Content

As reported through the opinions of registered nurses, the current Oklahoma law on health services for minors (63 O.S., Sections 2601-2602) was not being implemented uniformly throughout Oklahoma at the time of this study. Nurses were also divided on their opinions regarding minors' knowledge of services available without parental consent.

Based on these and other findings, the following recommendations are made:

1. Pre-service and in-service curricula for registered nurses should be examined for the possible inclusion of policy studies related to health services for minors.

2. Secondary school curricula should be reviewed for the possible inclusion of information regarding health laws that affect adolescents. In cases where the information is not provided, the assumptions underlying the omission should be examined.

3. The conflicts existing between recent Supreme Court decisions (Carey v. Population Services International, 1977; Jones v. T. H., 1976) and Oklahoma law (Sixty-three O.S., 1976) should be resolved. The resolutions of these conflicts would enable health professionals and the public in general to act with greater certainty regarding their rights and responsibilities.

4. Further studies should be undertaken to directly assess (1) minors' knowledge of the laws that affect them, (2) parents' perceptions regarding the impact of the Health Services for Minors Law on quality of family life, and (3) the perceptions of other health professionals regarding the implementation and impacts of the current law.

5. The State of Oklahoma should develop a system for reviewing the Health Services for Minors Law. It is assumed that the State Legislature enacted the law in an attempt to improve the quality of life for families. A more comprehensive study than the one reported here should be made.

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APPENDICES

APPENDIX A

HEALTH SERVICES FOR MINORS QUESTIONNAIRE

HEALTH SERVICES FOR MINORS QUESTIONNAIRE

Part I. REGISTERED NURSES' OPINIONS OF AVAILABILITY OF HEALTH SERVICES FOR MINORS WITHOUT PARENTAL CONSENT OR KNOWLEDGE

Directions: Each item in the left column is a health service that may be requested by a minor. The three columns on the right are designed to assess how you feel about the service being offered to minors in Oklahoma without parental consent or knowledge. Please read each item carefully then circle the letter in each of the three columns which best describes your feelings of whether the service should be available, the service is available, and minors know the service is available without parental consent or knowledge. The response scale is as follows:

U = Undecided
SD = Strongly disagree
D = Disagree
A = Agree
SA = Strongly agree

MARK ONE ANSWER IN EACH COLUMN FOR EACH ITEM!

SERVICE PROVIDED	Service SHOULD BE available in Oklahoma without parental consent or knowledge	Service IS available in Oklahoma without parental consent or knowledge	Minors KNOW service is available in Oklahoma without parental consent or knowledge
1. Treatment for pustular acne	U SD D A SA	U SD D A SA	U SD D A SA
2. Treatment for menstrual problems	U SD D A SA	U SD D A SA	U SD D A SA
3. Contraceptive services	U SD D A SA	U SD D A SA	U SD D A SA
4. Treatment for venereal disease	U SD D A SA	U SD D A SA	U SD D A SA
5. Abortion services	U SD D A SA	U SD D A SA	U SD D A SA
6. Treatment for obesity	U SD D A SA	U SD D A SA	U SD D A SA
7. Sterilization services	U SD D A SA	U SD D A SA	U SD D A SA
8. Pelvic examinations	U SD D A SA	U SD D A SA	U SD D A SA
9. Pregnancy testing	U SD D A SA	U SD D A SA	U SD D A SA
10. Breast examinations	U SD D A SA	U SD D A SA	U SD D A SA

Part II. PERCEIVED IMPACTS OF OKLAHOMA LAW REGARDING HEALTH SERVICES FOR MINORS WITHOUT PARENTAL CONSENT OR KNOWLEDGE

Oklahoma State Law 63 O. S., Sections 2601-2602 enacted in 1976 concerns health services for minors and the right of self-consent. It states that notwithstanding any other provision of law, the following minors may consent to have services provided by health professionals in the following cases:

1. married, emancipated or has a dependent child;
2. separated from and not supported by parents or legal guardian;
3. pregnant or has been pregnant;
4. consenting for the minor's child;
5. the spouse of a minor when minor is unable to give consent;
6. in need of emergency services for a condition that would endanger her life by waiting for a parent, spouse or legal guardian.

Directions: Listed below are possible impacts that this law may have had on adolescent pregnancy in Oklahoma. Please read the possible areas of impact carefully then circle the number on the scale that best describes your opinion of the impact of the current law. The scale ranges from 1 - 5 with one indicating a definite INCREASE and five indicating a definite DECREASE in the possible impact.

Possible areas of impact of 63 O. S., Sections 2601-2602	My opinion regarding possible impacts of 63 O. S., Sections 2601-2602				
	Decrease		No impact		Increase
11. Early contact with health professionals by pregnant minors	5	4	3	2	1
12. Repeat pregnancies by minors	5	4	3	2	1
13. Unlawful abortions by minors	5	4	3	2	1
14. Lawful abortions by minors	5	4	3	2	1
15. First pregnancies by minors	5	4	3	2	1
16. Health risks incurred by minors	5	4	3	2	1

Part III. COMMENTS

17. Do you think any changes are advisable in Oklahoma relating to health services for minors?

_____ yes _____ no

18. If Oklahoma law concerning provision of health services for minors were to change, what changes would you recommend?

19. For what reasons would you recommend these changes?

Part IV. BACKGROUND INFORMATION

Directions: For the five items below, please indicate your response in the blank to the right of the item. A map on the following page will provide information for you to indicate the state planning region in which you work. Remember, response data will not be associated with any individual.

20. Number of years I have worked in health services _____

21. Number of years I have worked in health services in my present community _____

22. Number of the state planning district in which I work (See attached map.) _____

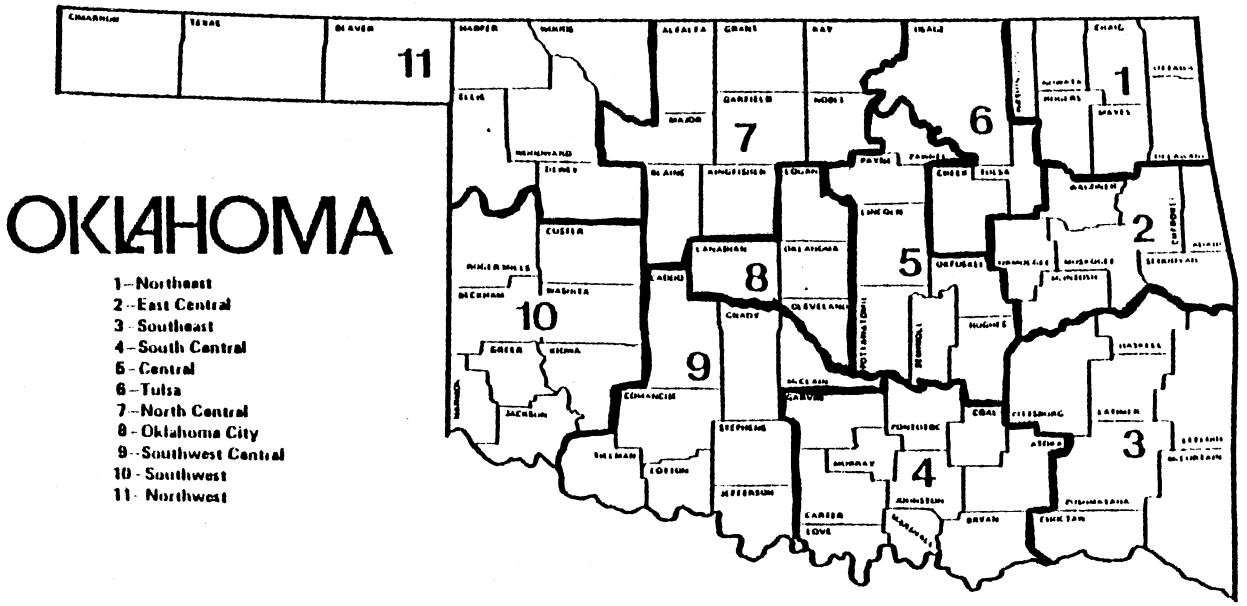
23. In my present position direct health services to minors are provided. yes _____ no _____

24. My current field of employment is (Check as many as apply.)

Hospital _____
Nursing home _____
School of nursing _____
Private duty _____
Public health _____
School nurse _____
Industrial nurse _____
Office nurse _____
Other, please write in _____

Thank you for your participation in this survey.

STATE PLANNING REGIONS
JULY 1, 1976



APPENDIX B

CORRESPONDENCE

Oklahoma State University

FAMILY STUDY CENTER

STILLWATER, OKLAHOMA 74078
114 HOME ECONOMICS WEST
(405) 624-6696 or 6697

April 24, 1981

Dear

This letter is to invite your participation in a research project being conducted at Oklahoma State University. Registered Nurses were selected as the population for this study because of their expertise and interest in teenage health problems and their contact with teens at the point of service delivery. The results of this survey will be provided to family life educators and health professionals who are interested in adolescent health problems.

The objectives of the study are to (1) identify the health services of special interest to minors that are available in Oklahoma without parental consent or knowledge, (2) determine the opinions of Registered Nurses in Oklahoma about health services being offered without parental consent or knowledge, (3) obtain the opinions of Registered Nurses concerning the impacts of Oklahoma law relating to health services for minors, and (4) determine whether there is a relationship between geographical location and the type of health services available without parental consent or knowledge to minors in Oklahoma.

Completing the questionnaire will take approximately twenty minutes of your time. After completion, please return it in the enclosed envelope by May 8. Data collected will not be associated with any individual by name, however, in order to be efficient in our follow-up procedures we do need to know who has returned the survey. Please complete the enclosed participation card and return it separately.

Your cooperation in this study is greatly appreciated.

Sincerely yours,

Beulah M. Hirschlein, Ph.D.
Faculty Associate, Family Study Center

Margaret Ann Berry
Graduate Research Assistant

Enclosure

Oklahoma State University

FAMILY STUDY CENTER

STILLWATER, OKLAHOMA 74078
114 HOME ECONOMICS WEST
(405) 624-6696 or 6697

May 28, 1981

Dear

In late April we mailed you a questionnaire concerning health services for minors. Since we have not received your record of participation card, we are sending you a second questionnaire and we encourage you to complete it at your earliest convenience. A self-addressed stamped envelope and participation card are enclosed.

We would like very much to receive your response by June 12. If you have already completed and returned the questionnaire, disregard this reminder.

Your response is important to us and we appreciate your cooperation. We do want to reassure you that your response is confidential and anonymous.

Sincerely yours,

Beulah M. Hirschlein, Ph.D.
Faculty Associate, Family Study Center

Margaret Ann Berry
Graduate Research Assistant

Enclosure

RECORD OF PARTICIPATION

Health Services for Minors Questionnaire

Name _____

Address _____

_____

_____

☐ Check this box to receive survey results.

APPENDIX C

DISTRIBUTION OF SAMPLE

TABLE LIV

DISTRIBUTION OF SAMPLE

State Planning District Number	Number of Questionnaires Sent	Number of Participation Cards Returned
1	16	7
2	31	16
3	10	10
4	19	11
5	18	12
6	97	30
7	29	13
8	180	67
9	32	16
10	10	5
11	4	0
Total	446	187[1]

[1]This number does not equal to 199 respondents used in the analysis because not all cards were returned with the questionnaire.

APPENDIX D

RESPONDENT COMMENTS

RESPONDENT COMMENTS

The following comments were not in response to questionnaire items. They were unsolicited and unanalyzed statements that were written by respondents at various places on the questionnaire and provided insight into the nurses' beliefs.

"We have only one body and it does belong to the individual."

"Information must be given at junior high and elementary levels - high school is too late."

"If parents are disinterested, child should have recourse through foster care, guidance agency, or some person."

"Many uneducated, basically ignorant, young teenagers are having children. These children have no or very erroneous contraceptive information."

"Bring back the book called Health Habits."

"It seems to me that if you are going to decrease births to teens then you have to do so before she becomes pregnant, not afterwards." (sic)

"If a fetus is to be regarded as a person, certainly a 'minor' should be."

"Minors need all the help they can get."

"Morality cannot be legislated."

"Minors in many parts of the state are denied basic health care and reproductive health care services. Not only are direct services denied but in some cases even education is severely limited."

"Where are the questions on drugs and alcohol?"

"Decision making is a responsibility for both males and females."

"I want my children to have the ability to seek proper medical care without my permission. It's time for Oklahoma State Teaching Hospital to step out front and teach good health care. We represent our state!"

"Most films that are viewed by minors are quite old and outdated."

"I'm not even sure of the current health services available now - especially at the county health clinic."

"Children are a gift of God. Do you throw your gifts out or put little or no value on them?"

"Proverbs 22:6 - Train up a child in the way he should go and when he is old he will not depart from it."

"We know from experience it is impossible to legislate morality but the safety of the child must be protected."

"Government must encourage parental responsibility instead of trying to play parents or God."

APPENDIX E

OKLAHOMA STATE LAW 63, O.S., SECTIONS 2601-2602

CHAPTER 54.—HEALTH SERVICES FOR MINORS [NEW]

Sec.
2601. Definitions.
2602. Right of self-consent under certain conditions—Doctor patient privileges.
2603. Payment for services.
2604. Safeguards to protect minor.
2605. Providing of health care not mandatory.
2606. Severability.

§ 2601. Definitions.—For the purposes of this act, the following words and phrases mean:

(a) "Minor" means any person under the age of eighteen (18) years of age, except such person who is on active duty with or has served in any branch of the Armed Services of the United States shall be considered an adult.

(b) "Health Professional" means for the purposes of this act any licensed physician, psychologist, dentist, osteopathic physician, podiatrist, chiropractor, registered or licensed practical nurse or physician's assistant.

(c) "Health Services" means services delivered by any health professional including examination, preventive and curative treatment, surgical, hospitalization, and psychological services, except abortion or sterilization. Should the health services include counseling concerning abortion, all alternatives will be fully presented to the minor. Services in this act shall not include research or experimentation with minors except where used in an attempt to preserve the life of that minor.

Added by Laws 1975, c. 225, § 1, emerg. eff. May 29, 1975. Amended by Laws 1976, c. 161, § 1.

Section 7 of Laws 1975, c. 225 directed codification.

Title of Act:

An Act relating to public health and safety; providing for health services for minors; defining terms; granting minors the right of self-consent under certain conditions; providing for exceptions to doctor patient privileges; providing for safeguards to protect the minor; directing codification; and declaring an emergency. Laws 1975, c. 225.

Infants ⇐*13, 50.*

§ 2602. Right of self-consent under certain conditions—Doctor patient privileges.—A. Notwithstanding any other provision of law, the following minors may consent to have services provided by health professionals in the following cases:

1. Any minor who is married, has a dependent child or is emancipated;

2. Any minor who is separated from his parents or legal guardian for whatever reason and is not supported by his parents or guardian;

3. Any minor who is or has been pregnant, afflicted with any reportable communicable disease, drug and substance abuse or abusive use of alcohol; provided, however, that such self-consent only applies to the prevention, diagnosis and treatment of those conditions specified in this section. Any health professional who accepts the responsibility of providing such health services also assumes the obli-

gation to provide counseling for the minor by a health professional. If the minor is found not to be pregnant nor suffering from a communicable disease nor drug or substance abuse nor abusive use of alcohol, the health professional shall not reveal any information whatsoever to the spouse, parent or legal guardian, without the consent of the minor;

4. Any minor parent as to his child;

5. Any spouse of a minor when the minor is unable to give consent by reason of physical or mental incapacity;

6. Any minor who by reason of physical or mental capacity cannot give consent and has no known relatives or legal guardian, if two physicians agree on the health service to be given; or

7. Any minor in need of emergency services for conditions which will endanger his health or life if delay would result by obtaining consent from his spouse, parent or legal guardian; provided, however, that the prescribing of any medicine or device for the prevention of pregnancy shall not be considered such an emergency service.

If any minor falsely represents that he may give consent and a health professional provides health services in good faith based upon that misrepresentation, the minor shall receive full services without the consent of the minor's parent or legal guardian and the health professional shall incur no liability except for negligence or intentional harm. Consent of the minor shall not be subject to later disaffirmance or revocation because of his minority.

B. The health professional shall be required to make a reasonable attempt to inform the spouse, parent or legal guardian of the minor of any treatment needed or provided under paragraph 7 of subsection A of this section. In all other instances the health professional may, but shall not be required to inform the spouse, parent or legal guardian of the minor of any treatment needed or provided. The judgment of the health professional as to notification shall be final, and his disclosure shall not constitute libel, slander, the breach of the right of privacy, the breach of the rule of privileged communication or result in any other breach that would incur liability.

Information about the minor obtained through care by a health professional under the provisions of this act shall not be disseminated to any health professional, school, law enforcement agency or official, court authority, government agency or official employer, without the consent of the minor, except through specific legal requirements or if the giving of the information is necessary to the health of the minor and public. Statistical reporting may be done when the minor's identity is kept confidential.

The health professional shall not incur criminal liability for action under the provisions of this act except for negligence or intentional harm.

Added by Laws 1975, c. 225, § 2, emerg. eff. May 29, 1975. Amended by Laws 1976, c. 161, § 2.

§ 2603. Payment for services.—The spouse, parents or legal guardian of the minor shall not be liable for payment for any health services provided under the authority of this act, unless they shall have expressly agreed to pay for such care. Minors consenting to health services shall thereby assume financial responsibility for the cost of said services except those who are proven unable to pay and who receive the services in public institutions.

Added by Laws 1975, c. 225, § 3, emerg. eff. May 29, 1975.

§ 2604. Safeguards to protect minor.—If major surgery, general anesthesia, or a life-threatening procedure has to be undertaken on a minor, it shall be necessary for the physician to obtain concurrence from another physician except in an emergency in a community where no other surgeon can be contacted within a reasonable time.

In cases where emergency care is needed and the minor is unable to give self-consent; a parent, spouse or legal guardian may authorize consent.

Added by Laws 1975, c. 225, § 4, emerg. eff. May 29, 1975.

§ 2605. Providing of health care not mandatory.—Nothing in this act shall require any health professional to provide health care nor shall any health professional be liable for refusal to give health care.

Added by Laws 1975, c. 225, § 5, emerg. eff. May 29, 1975.

§ 2606. Severability.—The provisions of this act are severable and if any part or provision hereof shall be held void the decision of the court so holding shall not affect or impair any of the remaining parts or provisions of this act.

Added by Laws 1975, c. 225, § 6, emerg. eff. May 29, 1975.

Statutes ⇐64(2).

VITA

Margaret Jennings Berry

Candidate for the Degree of

Doctor of Philosophy

Thesis: OPINIONS OF OKLAHOMA REGISTERED NURSES REGARDING HEALTH SERVICES FOR MINORS WITHOUT PARENTAL CONSENT OR KNOWLEDGE

Major Field: Home Economics - Home Economics Education

Biographical:

Personal Data: Born October 1, 1944, in Tipton, Oklahoma, the oldest child of Margaret and Talma G. Jennings, Jr. Married to Joe Gene Berry and the mother of three children, Jeffrey Gene, Janet Elizabeth, and Jonathan Garland Berry.

Education: Graduated from Tipton High School in May, 1962; received Bachelor of Science degree in Vocational Home Economics Education from Oklahoma State University in 1965; received Master of Science degree in Home Economics Education in 1967; was doctoral student with 52 graduate hours at Purdue University before enrolling at Oklahoma State University; completed requirements for the Doctor of Philosophy degree at Oklahoma State University in May, 1982.

Professional Experience: Graduate research assistant, Oklahoma State University, 1980-1982; graduate teaching assistant, 1982; Consultant to Oklahoma Egg Council, 1980-1982; Consultant to Indiana State Poultry Association, 1977-1982; Graduate research assistant, Purdue University, 1975-1979; Graduate teaching assistant, 1979; Instructor, Kansas State University, 1969; Adult education teacher, Manhattan Vocational School, 1967-1969; Vocational Home Economics teacher, Manhattan (Kan.) High School, 1967-1968; Research project secretary, Oklahoma State University, 1966-1967; Home Economics teacher, Marshall (Okla.) High School, 1965-1966.

Professional and Honor Organizations: American Home Economics Association, Oklahoma Home Economics Association, American Vocational Association, Oklahoma Vocational Association, Oklahoma Council on Family Relations, Omicron Nu, Phi Upsilon Omicron, Phi Kappa Phi, and Kappa Delta Pi.